# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

448 CERTIFICATE OF DEATH

00438

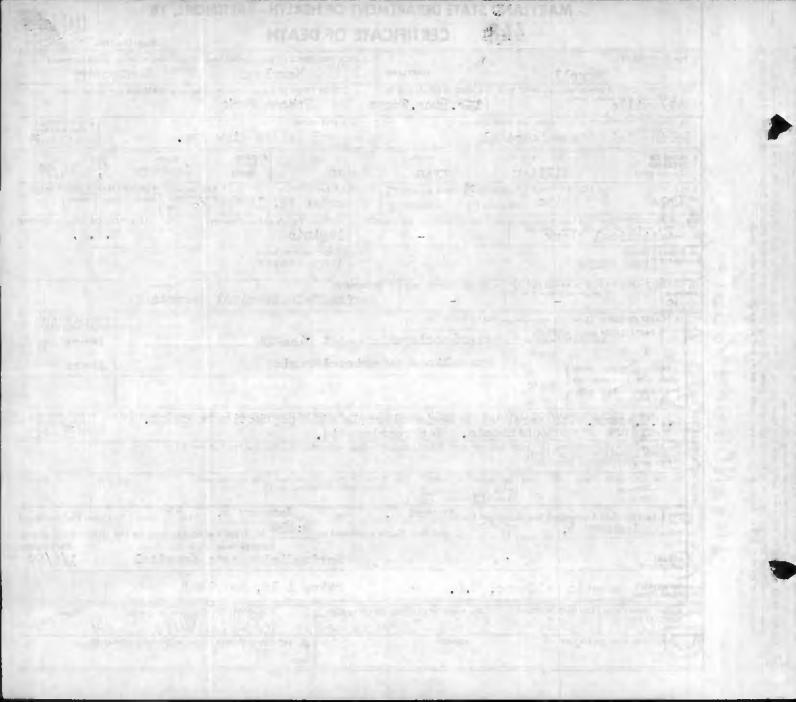
								Reg. Dis	t. No.	
1. PLACE OF DEATH o. COUNTY	Carroll		MARYLAND		usual residence (who state Mary.		d. If institution b. COUNTY		gomery	
Sykesville	If autside corporate limi earest tawn)	ls, write	c. LENGTH OF STAY IN 16		E. CITY OR TOWN (IF or	a Park	limits, write RL	IRAL ond g	ive nearest to	own)
d. NAME OF HOSPIT OR INSTITUTION Springfiel	TAL (If not in hospitol, of d State Hos	ive street spita	oddress)		d. STREET ADDRESS  3 Valle	ey View	Ave.		10	RESIDENCE N A FARM? NO P
J. NAME OF DECEASED (Type or print)	Willia		Middle Bryan	A	dams	4. DATE OF DEATH	Janu		6, Day	Yeor 1959
5. SEX Male	6. COLOR OR RACE White	7. MARR	NED MEVER MARRIED DIVORCED DIVORCED		ecember 14,	1896	GE (In years ost birthday) 62 yrs.		Doys Hou	NDER 24 HRS.
during most of wor	ON (Give kind of work king life, even if refired CAL CLERK	done 10b.	KIND OF BUSINESS OR INDU	STRY	Virginia	or foreign country	y)	1	U.S.A.	HAT COUNTRY
William A	dams			14	Fanny Weav					
	R IN U. S. ARMED FOR (If yes, give wor or dotes of s				mant ringfield H	ospital	Record			
	ATH (Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO	A	ne for (o), (b), and (c).]	c.l	meart diseas	36				BETWEEN ND DEATH
Conditions, if o gove rise to i couse (a), stoting lying couse lost.	my, which	G	eneralized art	eri	iosclerosis				Year	*5
C.B.S.ass Termina 200. ACCIDENT WOOD OF CONTRIBUTION OF CONTRIBUTION	HER SIGNIFICANT CON	SARGING	Tarter Posciet nia. Nephrosc	්ල් lei	is with hepsy rosis.	thotae-9	yetsk <del>s</del> h	H IN PART	1(o) 19. WA PER YES	
	AS UNDERLYING TO CAUSE OF DEATH!  MEDICAL EXAMINERS	20b. DES	CRIBE HOW INJURY OCCURRE	D. (Er	nter noture of injury in Po	ort I ar Port II o	f item 1B.)			
20c. TIME OF INJUR Hour o. m. p. m.	RY Month, Doy, Ye	While of wor	Not white for		OF INJURY (Home, form, street, office bldg., etc.)		own)	(C	ounty]	(Stole)
21. I certify the alive an Jant	nat I attended the	deceas	ed framAugust 4,	occ	orred at 8:43A	"M, Huin in	e couses a	nd on th		
ACTUAL SIGNATURE	quistin	di	1 Carrefor	M.D.	Springfie	Id State			-	1/6/59
PHYSICIAN'S A	gustin delC	ampo,	M.D. /		Sykesvill	e, Mary	land			PR
220. BURIAL CREMATIC SEMOVAL (Specify)	ON. 226. DATE THEREC	oF ?	22c NAME OF CEMEJERY O	RERI	Comeliny	Mines Mines	Slore	County)	will ,	State) M/.
23 FUNERAL PIRECTOR	Charles	254	RADDRESS WAS	41	Z D.C. No. REC'D	BY REGISTRAR	24b, REG/S	TRAR'S SIG	PARENA	

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, crematian, ar removal, and in any event within 72 hours after death. uneral director, by the haspital or otherding physician. TO FUNERAL D

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of

TO HOSPITAL

r death. Page 4



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death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after

VS A15 (4) 1SM 10/S7

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00439

449

**CERTIFICATE OF DEATH** 

Reg. Dist. No.

								Mag. Dist.	110.		
1. PLACE OF DEATH	77		MARYLAI	- 11	USUAL RESIDENCE (V		d lived. If instituti b. COUNTY	an: Residence	before adm	nission)	
	roll				Maryland Carroll						
RURAL and give n			60 vorts	16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)  Tanevtown						
	TAL (If not in hospital, give :	street oddr	en)		d. STREET ADDRESS	AMONIA			a   S   E	ESIDENCE	
OR INSTITUTION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			11/	d. SIRCEI ADDRESS				. OV	A FARM?	
					Frede	rick S	treet		YES	□ NO □	
3. NAME OF	First		Middle		Lost	4. DATE	Man	th	Day	Year	
(Type or print)	Agne	95	C.		Arnold	OF DEATH	January	7	21.	19 59	
5. SEX	6. COLOR OR RACE 7.	MARRIED	NEVER MARRIED	8. D	ATE OF BIRTH		9. AGE (In years	IF UNDER 1		IDER 24 HRS.	
Female	White Wi	DOWED [	DIVORCED T	Ja	n. 21. 187	70	fost birthdoy)	Manths D	ays Hou	rs Min,	
	ON (Give kind of work dane	Press	3				0	Ing. CITIZ	ENI CIE WILL	AT COUNTRY	
Housewor	king life, even it refired)	-	home	14003181	Marylan		ounty		D.A.	AI COUNIKI	
13. FATHER'S NAME		1 - 10 22		11	4. MOTHER'S MAIDEN				WAR.		
A											
	stine Arnold					J. Spa.	lding				
15. WAS DECEASED EVI	ER IN U. S. ARMED FORCES? (If yes, give wor or dates of service	16. SOC	IAL SECURITY NO.	17. INFO	RMANT		Add	ress			
no	in last fire and or other or leaves		one	Cha	rles R. Ar	mold,	Taneytown	Mary	land		
18. CAUSE OF DE	ATH [Enter only one cause	per line fa	r (a), (b), and (c).]				**		INTERVAL		
PART I. DE	ATH WAS CAUSED BY:	Ca		1	Terrian	-1-			ONSET AN		
2200	IMMEDIATE CAUSE (a)	1			CETER	La C. Mar Con-	1.1		6	no	
334X	DUE TO		er 1	. 5							
Conditions, if o			Serile	ly					7	wes	
gove rism to i				0		n			1	1	
lying couse lost.		Con	12 hund	an	FLYIAN	Alex	2011		10	UKS	
PART II. OT	HER SIGNIFICANT CONDITION	ONS CONT	TRIBUTING TO DEATH	BUT NO	T RELATED TO THE TER	MINAL DISEAS	E CONDITION GIV	EN IN PART 1	PER	1	
200. ACCIDENT W	AS UNDERLYING 1 206	. DESCRIBE	HOW INJURY OCCL	JRRED. (E	nter nature of injury in	n Part I or Part	t II of item 18.)		71.0		
	MEDICAL EXAMINER)										
20c. TIME OF INJUI		20d. INJUR While	Y OCCURRED 20e	e. PLACE factory	OF INJURY (Home, for street, office bldg., e	rm, 20f. (City	or lawn)	{Cos	unty)	(State)	
₽. m.		1 work									
21 Leartify th	not I attended the de	cented f	nom Aug	7	, 1957, to S	Jan 2	1 1058	Tues I In	. t th	e deceased	
N. A.			77		- 1						
alive an	east-let-	1527	$\cdot, -$ and that de	oth ac	curred at 2.2.				date sta	ated abave	
1	A 1. D	11				ADDRESS (SI	treet, city or lawn,	slote]	,	DATE SIGNED	
SIGNATURE	a amblew	ther	upsau	ALD.	Taura	Taire	bu d	)	1/2	23/59	
	"		11	141.0	d		- 4C-5m E-JKJ L-J	h-4			
PHYSICIAN'S NAME (Type)	Ambler	-76	empsa	37	1/						
220. BURIAL, CREMATIC REMOVAL (Specify)	ON, 22b. DATE THEREOF	22	. NAME OF CEMETER	RY OR CR	EMATORY	22d, 10CA	TION (City, lawn, o	or county)	(\$1	lote)	
Burial	Jan. 24. 194	59 5	St. Joseph	's C	emeterv	Tane	extown. N	arvlar	nd.		
23. FUNERAL DIRECTOR			ADDRESS	-		C'D BY REGIST		TRAR'S SIGN	ATURE		
C D Francis	you Cou	10				N 26 39		· 8 L	7 . 1		
C.U.Fuss	& Son, Taneyt	lown,	Maryland		DATE	THE W. D. D.C.	2000	- 14	Settle.		

A. LOW- T. ST. SECONOLIS SHIP THE THE STATE OF A SECURIOR AND STATE OF THE SECONOLIS SHIP AND SECONOLIS SHIP HIVEO TO STADETITUDE 155, 15 - 42 - 43 - 131 And the state of t in the growth of the state of t 15

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within 24 haurs after death. If any delay is nearly B. Give Pages 1, 2, and 3 to the funeral dirag with form PM3. Page 5 may be retained Mermit. File pages 1 and 2 with the State Barr after death.

(Slote)

	ME	DICAL	EXAMINER'	S CERTIFICA	ATE OF	DEATH	Reg. Dist.	No.			
PLACE OF DEATH	arroll	· ·	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (1) Ond give reduct lower Sykesvill			Syrs.7mos.6d	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)  Annapolis (Edgewater) 0 2 x 2							
d. NAME OF HOSPIT	al or institution (if	not in hospite		d. STREET ADDRES	55			e. 15 1 ON	RESIDENCE LA FARM? NO K		
NAME OF DECEASED (Type or print)	Paul		Middle Stevens	Eassford	4. DATE OF DEATH	Month January		20	Yeer 19 59		
. sex Male	6. COLOR OR RACE White	7. MARRIED WIDOWED [	NEVER MARRIED D	8. DATE OF BIRTH August 6,	1907	9. AGE (In years lost brithday) 51 yrs.	Months Day		Min.		
00. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Laborer				stry 11. Birthplace (S. Mary)		country)		U.S.A.			
James H.	Bassford				N NAME Visquith	1					
5. WAS DECEASED EV	/ER IN U. S. ARMED FOR (If yes, give wor or dates of s	ervice)	17-38-4158	Springfiel	ld Hospi	Address Ltal Recor	rds				
	ATH (Enter only one cous.  TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO		(o), (b), and (c).] ourative nep	hritis, acut	te		3 €	Days	ETT2 ATH		
Conditions, if a gave rise to imme (e), staling the couse last.	diate cause	Abs	cess of pros	tate				Weeks			
Subdura	l hematoma.		RIBUTING TO GEATH BUT AUMA WITT PS				psy.	19. WAS PERFO YES	AUTOPSY DRMED? NO		
20g. EXTERNAL CA PRIMARY () = CO CAUSE OF DEATH.	USE WAS THE PROPERTY OF THE PR		ow injury occurred.  n floor duri				ations.				
Unknown			URY OCCURRED 20e PL	ACE OF INJURY (Home, it clory, street, office bldg., Spital	efc.)	/kesville	Carr		(Stote) Md.		
			noins described ab			nspection N, Undeter	Inquiry mined man		nd in my		
ACTUAL SIGNATURE	uce I	Mas	sh!	M.D.	L EXAMINER [			DATE	SIGNED		
EXAMINER'S	James T. Ma	rsh. M	D.		AL EXAMINER I			2/1/5	9		

22c. NAME OF CEMETERY OR CREMATORY

Annapolis, Maryland

Cedar Bluff Cemetery

22d. LOCATION (City, town, or county)

240. REC'D BY REGISTRAR

DATE FEB 5

Annapolis, Maryland
BY REGISTRAR | 246, REGISTRAR'S SIGNATURE

ally & King

execute the central process, writing the word "pending" in pending in Ilem, 18. Give Pages 1, 4 should be for anded to the Chief Medical Examiner's Office along with form PM3. PTO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 are its designated agent, prior to burial, cremation, at removal, and in any event within

220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)

VS. A15ME 5M 2/57

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#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

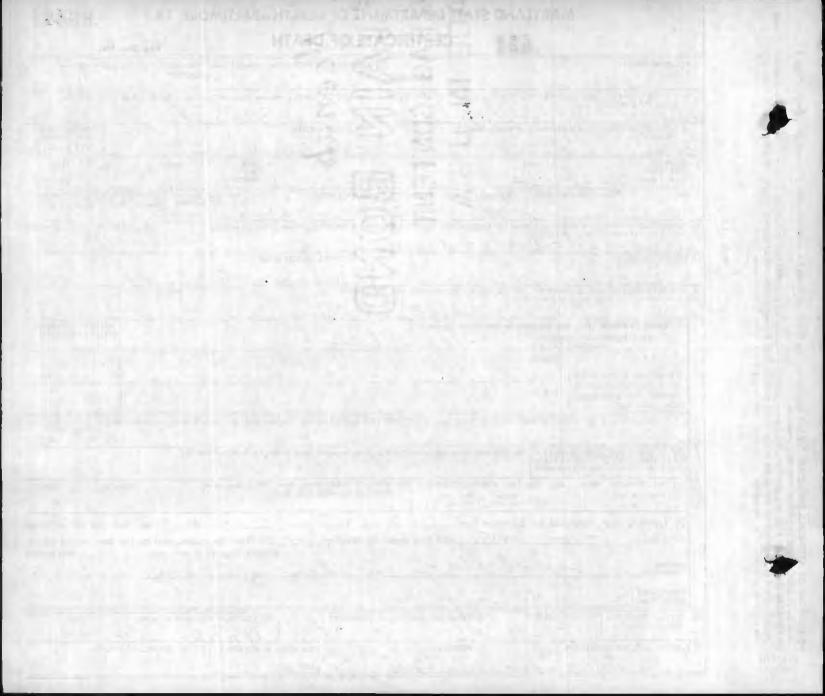
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- 7.	
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-2	4.5

#### CERTIFICATE OF DEATH

-	301	Reg. Dist. No.					
1	PLACE OF DEATH  O. COUNTY  MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY ARRIVATION 14 RR 01.1.					
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town)					
	UNION BRIDGE YEARS	XUNIAN BRINGE					
	d. NAME OF HOSPITAL (If not in hospital, give street oddress)  REALE OF ALLIAN ST	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES ON O					
3	NAME OF First Middle	Lost 4. DATE Month Day Year					
	(Type or print) PEREVILLE JANE	BOND DEATH JAN 2 19.5					
1	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.					
Ĭ.	FEMALE WILLE WIDOWED DIVORCED	Alsc 15-1844 (Lyrs Months Days Hours Min.					
ī	Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if retired)	STRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY					
1	HOUSEKEEDER AT HOME	MARYIANN U.S.					
F	3. FÄTHER'S NAME	14. MOTHER'S MAIDEN NAME					
1	CORNELIUS BOND	HANNAH ENGLAR					
	5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IP	NFORMANT Address					
	NO NO NONELL	V. BOND DNION BRIDGE MIN.					
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH					
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0)	lety on the letter					
	33/X DUE TO 0 11 17						
1	Conditions, if any, which) (b) Left level	ral hemorrhour					
	gove rise to immediate couse (a), stating the under-						
1.	lying cause lost. (c)						
3	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?					
1	20. ACCIDENCE WAS INCOMINATED TO A DESCRIPTION OF THE PROPERTY	YES NO					
		D. (Enter nature of injury in Part I or Part II of item 18.)					
14.00	Co. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLA for on m. 19 While Not work of the college of	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) story, street, office bldg., etc.)					
1	10-1	20 50 /- 1 -					
		30, 19.28, to, 19.5.7, that I last saw the deceased					
Н	alive an 19.27 and that death	accurred at 140 M, from the causes and an the date stated above					
1	ACTUAL // Lea	Aboress (Street, ) ity or town, state)  DATE SIGNET					
	SIGNATURE	4.0. muise my					
	PHYSICIAN'S NAME (Type) 1. H. Legg						
2	20. BURIAL, CREMATION, 22b. DATE THEREOF 22C NAME OF CEMETERY OF	R CREMATORY 22d. LOCATION (City, town, or county) (State)					
	BURIHU 115/57 METHODIS	T CEMIDOHNSVILLE MD					
2	FUNERAL DIRECTOR'S SIGNATURE	24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE					
1	III Har Burt Jour Muon Bud	ge MC DATERN 5 159 Dellar & Kines					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death: Page 4 VS A15 (4) 15M 10/57



#### CERTIFICATE OF DEATH

00442

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200	Keg. Dist	, No.
1. PLACE OF DEATH a. COUNTY RELITABLE MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Regidence a. STATE MULLIPLE OF B. COUNTY CLU	noll
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (It outside corporate limits, write RURAL and gi	ve nearest fown)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) JESSIE - EVANS - BO	OULTON 4. DATE OF DEATH JULE 29	7 Doy Yeor 1959
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	The state of the s	YEAR IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, eyen if retired)	STRY 11. BIRTHPLACE (Stole or loreign country)  12. CITIZ	US A
13. FATHER'S NAME	Elizabeth Mitchell	L SEV
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN 1995 no. or unknown) 16. Social Security No. 17. IN 1995 no. or dotten of service)	NFORMANT) us Louise Idlett- address:	a ned
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	al Obstruction	INTERVAL BETWEEN ONSET AND DEATH
Canditians, il any, which ) (b)		1
gave rise to immediate couse (a), stating the under-lying cause tast.    DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  TO CONTRIBUTING   200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	D. (Enter nature of ihjury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m.  19 While Not while at work at work	ACE OF INJURY (Home, farm, 20f. (City or town) (Cotory, street, office bldg., etc.)	ounty) (State)
21. I certify that I attended the deceased from from alive an January 37 1959 and that death	2.0/	ost saw the deceased
actual SIGNATURE W 170000	ADDRESS (Street, city or town, stote)	DATE SIGNED
PHYSICIAN'S WHFOARD MD	Manchester, Ma	/
220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OF PREMOVAL (Specify) Jan 29/5 9 Weller	R CREMATORY 220 LOCATION (City, town, or county)	Med (State)
22-FUNERAL DIRECTOR'S SIGNATURE HOLLESS ADDRESS	240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGN DATE AN 3 0 '59 Online & 1	NATURE Gard

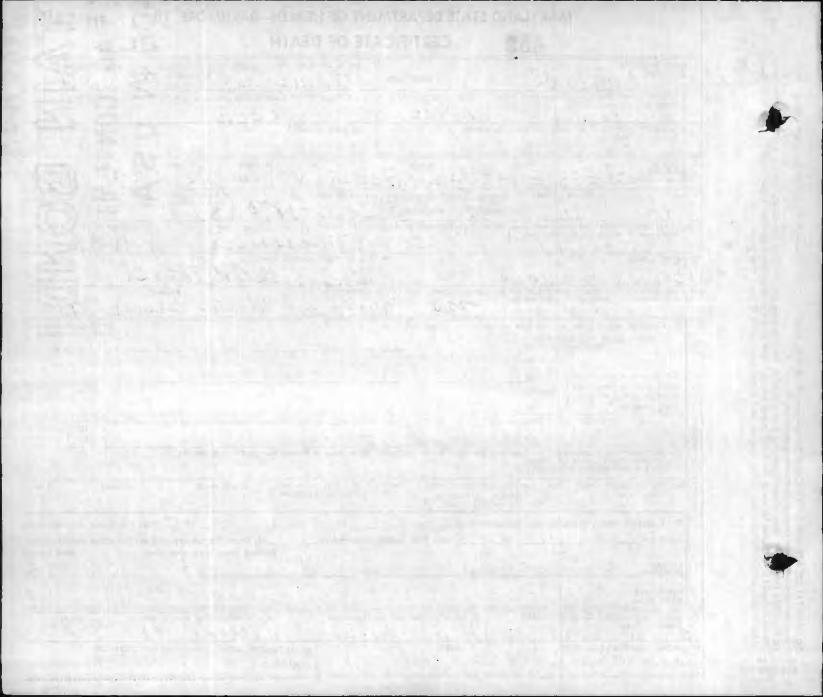
TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after may be retained. The hospital or attending physician.

TO FUNERAL DIRECTORY. After this certificate has been signed by the attending physician and campletely filled in by the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sty the registrar prior to burial, cumotion, ar removal, and in any event within 72 hours after-death.

TO HOSPITAL OR

VS A15 (4) 15M 10/57

death. Page 4



Reg. Dist. No.

uneral director

Page 4

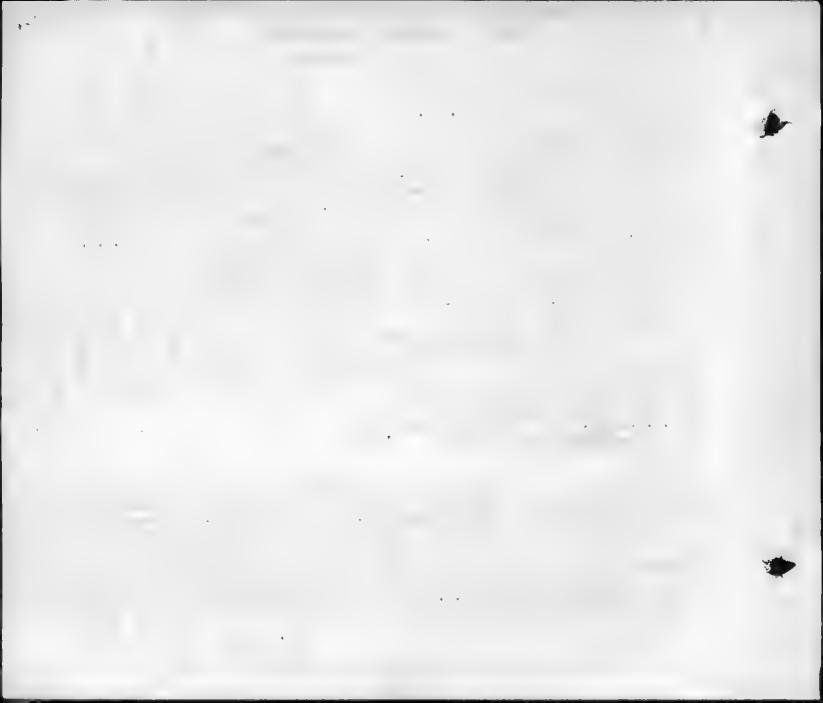
may be retain. By the haspital or ottending physician.

TO FUNERAL DIT TOR: After this certificate has been signed by the attending physician and campletely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, or remayal, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

TO HOSPITAL OF VS A15 (4) ISM 9/SS

	PLACE OF DEATH  O COUNTY  O THE PLACE OF DEATH			2. USUAL RESIDENCE (V	Vhere deceased	lived If institution	ni Residenc	e before od	mission)		
L	Car	roll		MARYL	AND	Merry	/ Xanki/	B. COURT	Mon	toons	f V
	<ul> <li>CITY OR TOWN (If RURAL and give ne</li> </ul>	outside corporate fimi arest town)	ts, write	c. LENGTH OF STAY II	N 1b	c. CITY OR TOWN (II	outside corpor	ate limits, write RU	IRAL and g	ive nearest t	own)
	Sykesvil	le		lyr.lmo.19	day	s Silver	Spring	Washing	gton,	D. C	•
	d NAME OF HOSPITA					d STREET ADDRESS		orter St		W . e. 15	RESIDENCE N A FARM?
	Springfi	eld State	Hosp:	ital		MeDeau/Gard	lety Kor,	sing/Home	1	YES	□ NO M
3.	NAME OF DECEASED	Fi	4.	Middle		Lost	4. DATE OF	Mont	h	Doy	Year
-	(Type or print)	Sylv		0		itee Bradley	DEATH	Januar	V	23,	1959
5.	SEX		7 MAR	RIED NEVER MARRIET		DATE OF BIRTH		9. AGE (In years lost pirthdoy)		Days Hou	NDER 24 HRS
L	Female	White	WIDOW	PED DIVORCED		May 7, 1873		85 ym.	avigatinis .	Odys Hot	JYS WIII.
10c	<ul> <li>USUAL OCCUPATIO during most of working</li> </ul>	N (Give kind of work ing tife, even if retired	done 10b	KIND OF BUSINESS OR	INDUS	STRY 11 BIRTHPLACE (Stat	te or foreign co	untry)	12. CITI	ZEN OF WE	HAT COUNTRY
	Housewife			-		Maryland	ł		ប្រ	.S.A.	
13.	FATHER'S NAME					14 MOTHER'S MAIDEN	NAME		_		
	Sylvester	Macatee				Mary Jan	e Perki	ins			
15.	WAS DECEASED EVER	IN U. S. ARMED FOR		SOCIAL SECURITY NO	17. If	NFORMANT		Addr	ess		
	NO (1	00		-		Springfield	Hospit	1 Record	5		
	18. CAUSE OF DEAT	TH [Enter only one co	usa per li	ine for (o), (b), and (c) ]						INTERVAL	BETWEEN
	PART I. DEAT	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	, 1	Bronchopneum	oni	.8				Da	HTASO DA
	491 X	DUE TO								1	
	Conditions, if an	y, which ) (b	1								
	gave rise to in cause (a), slating t	mediate (									
	lying cause last.	ne <u>ungers</u>	1								
Z	C BAGII. OTH	ER SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEAT	TH BUT	NOT RELATED TO THE TER	M NAL DISEASE	CONDITION GIVE	N IN PART	1(o) 19 W	AS AUTOPSY
CATION	Marked g	eneralized	art	erioscherios	cte:	NOT RELATED TO THE TERM  POSIS WITH P	sychoti	.c reacti	on.	YES	NO A
CERTIFIC		S UNDERLYING  CAUSE OF DEATH				CEnter noture of injury in					
	IF EITHER, NOTIFY	MEDICAL EXAMINER)									
ČAL	20c TIME OF INJURY	Manth, Doy, Ye			10e. Pt/	ACE OF INJURY (Home, for	m, 20f (City	or tawn)	(C	ounty}	(State)
MEDICAL	Hour a m, p. m.	19	While at wo		100	tary, street, affice bldg , e	ic ) !				
		at Lattended the	docon	ed from Decem	her	4, 19.57, to J	שמפוומפ	23 10 50	that I I		
П	alive on Jar					accurred at 12:5					
	Cilve Oil		١٧	A and more	neum A	accorred dilling.		reet, city or town, s		e date st	DATE SIGNE
	ACTUAL	minta:	de	I Cam	. /2.	M.D. Springfi	-			7/	123/59
	. 11	FLAULUS -		~ waze	1	M.D OPTIMIE	014 500	oc noppt	ng#		-924-2Z
	PHYSICIAN'S NAME (Type)	gustin del	Camo	O. M.D.	f	Sykesvil	le, Mar	yland			
220	BURIAL, CREMATION			22c NAME OF CEMET	ERY OI	R CREMATORY	22d. LOCAT	ION (City, town, o	r county)	(	State)
	REMOVAL (Specify)	1-267	1450	ST. MAK	243	S PYLESUIL		YARFA	D I)	1.0	MO
23.	FUNERAL DIRECTOR'S	SIGNATURE	n	ADDRESS			C'D BY REGISTI	RAR 24b. REGIS	TRAR'S SIG	NATURE	
	1. The	eter Cos	elel	En 54441	361	LAIR RADAUAI	N 2 7 '59	0 11	18 10	lauld	
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### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

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NDIN e hos ched ched vriot,	
ATTE TOR TOR	
TO HOSPITAL OR ATTENDING PHYSIC IN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retain.  TO FUNERAL DI TIOR: After this certificate has been signed by the attending physician and campletely filled in by the corporation of the registrar prior to buriol, cremation, or remayal, and in any event within 72 hours after death.	
PITAL RAL show istror	
HOSI Oy by Bge 3	220
5 E O g =	23 <sub>A</sub>

VS A15 (4) ISM 9/SS

L		494	GENTIII	CA1					Reg. Dist	No.	
۲.	PLACE OF DEATH o. COUNTY	Carroll	MARYLAI		USUAL RESIDENCE. STATE	e (Whe	ere deceased live	b. COUNTY	n: Residence	before odn	Jission)
	B. CITY OR TOWN RURAL and give of Sykesvi	(If autside corporate limits, write nearest town)	c. LENGTH OF STAY IN	16	c. city or town	N (If ou	itside corporate	limits, write RU	JRAL and gi	re nearest to	iwn)
		MAL (If not in hospitol, give street ield State Ho			d STREET ADDR	ESS	Lkner 1	Place		40	RESIDENCE A FARM?
3	NAME OF DECEASED (Type or print)	ornelius E	ick Middle	Brok	Lost AW		4 DATE OF DEATH	Janu		9 Day	Year 19 <sup>59</sup>
5.	sex male	6. COLOR OR RACE 7. MARR	IED NEVER MARRIED		are of Birth	89	9. 4	GE (In years ost birthday)  O yrs.	Months D	YEAR IF UN	DER 24 HRS.
	o. USUAL OCCUPATION during most of world echanic	ON (Give kind of work done 10b rking life, even if refired)  — Constructi			11. BIRTHPLACE New			γ)	1	EN OF WH	AT COUNTRY
13	FATHER'S NAME	H.		1	. MOTHER'S MAI	DEN N	AME				
	Corneliu	ıs Brokaw			Marga	iret	t : S1	wick			
	WAS DECEASED EVI	Old as an a series alone of a series	SOCIAL SECURITY NO. 19-18-2205	Rec	mant ords of	, SI	pringf	ield S		Hosp	ital
18. CAUSE OF DEATH (Enter only one couse per line for (o). (b). and (c).]  PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o) Arteriosclerotic Cardiovascgular Disease Indirection of Indir								ors ers			
CERTIFICAT		ism, Growth of AS UNDERLYING CAUSE OF DEATH AS UNDERLYING CAUSE OF CAUSE O	Or Nutrition						e wi	th YES	
MEDICAL	20c, TIME OF INJUI Hour o.m. p.m.	While	JURY OCCURRED 20e Not white of work	PLACE foctory.	OF INJURY (Home street, office bldg	, form, J , etc.}	20f. (City or I	own}	(Co	unly]	(State)
	21. I certify the alive on Tan actual signature.  PHYSICIAN'S NAME (Type)	Vally Kin	ed from Aug 19	ath oc	curred at 5.	50, ingi	.M, fram th DDRESS (Street,	e causes as city or town, s	nd on the rote) Hospi	date sto	DATE SIGNE
22 TT	O. BURIAL, CREMAT C	DN. 226 DATE THEREOF 1 RIAL 1/13/59	22c. NAME OF CEMETER ST. JAMES LI		EMATORY RAN CEMET	CER	22d LOCATION PHIL	Lipsbul	&Gunly NE	W JER	ole) OE Y
17	Payman a	F / A Th	SILVER SPRI	NG, 1		REC'D	BY REGISTRAR 2 '59		TRAR'S SIGN		



Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. COUNTY **b. COUNTY** Montgomery Maryland  ${\tt Carroll}$ b, CITY OR TOWN (If outside corporate limits, write c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 RURAL and give nearest town) Chevy Chase 7 m 28 d Sykesville d NAME OF HOSPITAL (If not in hospital, give street address) IS RESIDENCE Conn. Avenue OR INSTITUTION ON A FARM? /Hast/ Home YES NO 7 Springfield State Hospital Gedar/ Haven NAME OF Middle Yeor 1959 Buffin DEATH (Type or print) Smith Margaret 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 8 DATE OF BIRTH lost birthdoy) Months Days DIVORCED [ 16 - 20 -68 WIDOWED I 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Virginia housewife retired own home 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Margaret Braughner Charles Smith 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address Springfield State Hospital Records No no INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] FART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease vears DUE TO Conditions, if ony, which gove tite to immediate **DUE TO** couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELATED TO THE TERMINAL DISEASE CONDITION GIVEN THE TART 1(0) 19.

C.B.S. assoc. with disturbance of metabolism, growth or muchiculation senile brain disease, with psychotic reactions YES NO or contributing of cause of death of was found in bed unable to move her left, x-ray exam.

The either notice which examiner revealed a fracture of the neck of femur. M.E. released the body Pay. Year 20d INJURY OCCURRED While Not while 20e PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Not while of work foctory, street, office bldg , etc.) Hour o. m. ( Carroll 6-ty Sykesville, Md. of work of work hospital ward p. m. 21. 1 certify that I attended the deceased from 5- 26 - 19.55, ta 19 59 , and that death accurred at 2:05 PM, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED 1-24-59。 Mp. Springfield State Hospital PHYSICIAN'S Sykesville, Maryland. Edmund Lusthaus M.D. NAME (Type) 220 BURIAL CREMATION, 27b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Falls Church, Va. Burial Jan. 27.1959 Oakwood Cemetery ADDRESS **FUNERAL DIRECTOR'S SIGNATURE** 24b. REGISTRAR'S SIGNATURE 24s. REC'D BY REGISTRAR Warner E. Pumphrey, Inc., Silver Spring, Md.

DAMIN 2 7 '59

Civilian S. Frank

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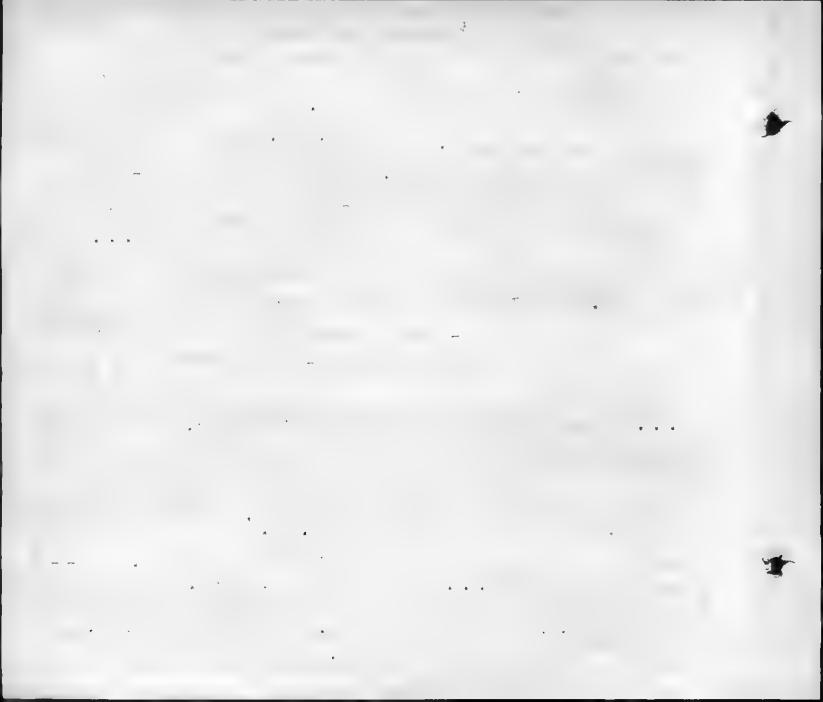
		400			•	R	log. Dist.	No.	
1, PLI 0.	ACE OF DEATH COUNTY	Carroll	MARYLAND	2 USUAL RESIDENCE (WHO O. STATE MARY.	ere deceosed lived Land	t. If institutions b. COUNTY	Residence I	before admission}	
ь	RURAL and give no	f outside corporate limits, was earest town) SVILLE	6yrsumths 9dy		utside corporete li	mits, write RUR	RURAL and give nearest town)		
d.	OR INSTITUTION	Al (If not in hospital, give st	,	d. STREET ADDRESS Rt.#3,Mt.	Airy			e. IS RESIDENC ON A FARM YES NO	?
DE	AME OF CEASED (pe or print)	Willia	Middle	Burdette	4. DATE OF DEATH	Month 1	•	Day Year 4 = 1955	9
5. SE)	ale	0.75 0.0	MARRIED NEVER MARRIED	7-1-1696	9. AC	and the second	UNDER I Y		
	USUAL OCCUPATION Suring most of work armer	ON (Give kind of work done king life, even if retired)	106 KIND OF BUSINESS OR INDU	STRY 11 BIRTHPLACE (Stole Maryland	or foreign country	)	U.S.	N OF WHAT COUN	ITRYT
13. FA	THER'S NAME			14. MOTHER'S MAIDEN N					
		George Burde		Viclette	Mullina				
(Yer o	o or unknown!	RINU S. ARMED FORCES? PtiWorld Ward		NFORMANT OSPITAL record	is	Address			
16		(0,	Gastro-Intestina	1 Hemorrhage				INTERVAL BETWEEN ONSET AND DEAT CAYS	4 4
- C	Conditions, if o gove rise to in couse (o), stoling lying couse lost.	mmediate the under- (c) (c)	Malignancy of th					months	
CERTIFICATION	- B-S-Wlt	n cerebral ar	THE CONTRIBUTING TO DEATH BUT	ith psychotic	reactio	ns.	IN PART 1	PERFORMED?	X.
	OR CONTRIBUTING	AS UNDERLYING   20b   CAUSE OF DEATH   MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	D (Enter nature of injury in P	ort tar Part II of	item 18.)			
■EDICAL 30	c. TIME OF INJUR Hour o. m. p. m.	W	Od INJURY OCCURRED 20e PL  Thile Nat while work at work	ACE OF INJURY (Hame, farm, clory, street, affice bldg., etc.	20f (City or to	wn}	(Cau	nty) (Sto	ote)
q	ctual ignature	pestri .	1959 , and that death	occurred at 8.45 A	ADDRESS (Street, o	causes and city or lown, stored Hospita	d an the	t saw the decedate stated about BATE SIG	OVE
N	AME (Type)	gustin del Ca		Sykesville					
Bů	EMOVAL (Specify)	Jan. 6,195		Meth.		ttsvil	le, l	Md. (Stote)	
23 60	JUN L	Molisunt	th Damascus	240. REC'E	BY REGISTRAR	24b REGISTR	AR'S SIGNA	ATURE	
							4		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIT MOR: After this certificate has been signed by the attending physician and completely filled in by the function page 3 shauld be detached far use as the burial-transit permit. Then please remove? Copon papers. Pages 1 and 2/mostle be filed with the registrar prior to burial, cremation, ar remaval, and in any event within 72 fours after death. VS A15 (4) 15M 9/55



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# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

U	()	4	4	1

DATE SIGNED

(State)

4		4:	CERTIFIC	ATE OF DEATH	1		Reg. Dist.	No.			
	1. PLACE OF DEATH a. COUNTY	arroll	MARYLANG	and 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE b. COUNTY  Maryland							
	b CITY OR TOW RURAL and giv	N (If outside corporate limi e negrest town)	s, write c. LENGTH OF STAY IN 18	CITY OR TOWN (IF a		prote limits, write R	URAL and give	nearest tow	n)		
	Sykesvil		5yr.2mo.26ds		18		VOL	2,6			
/	OR INSTITUTIO	SPITAL (If not in hospital, g ON Old State Hos		d. STREET ADDRESS	ster /	Ave-			SIDENCE A FARM? NO 🚰		
	3. NAME OF	Fir		lost	4. DATE	Mon	th	Day	Year		
	(Type or print)	Edward	Oscar	Burger	DEATH	January	, ;	,	19 59		
	5. SEX	6. COLOR OR RACE	7. MARRIED NEVER MARRIED WIDOWED DIVORCED			9. AGE (in years lost birthday) 67 yrs.		AR IF UND	ER 24 HRS Min.		
	Ma Te 100 USUAL OCCUPA during most of to	ATION (Give kind of work of working life, even if retired	done 106, KIND OF BUSINESS OR INI	October 18. DUSTRY 11 BIRTHPLACE (SIGNE	or foreign c	ountry)			T COUNTRY?		
_		tal Worker	Yellaw Cab Co			d	U.8	S.A.			
E	13. FATHER'S NAME			14 MOTHER'S MAIDEN N		- 1 T					
# /	Unknown			mina Kammerer							
1,5"	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address  16. SOCIAL SECURITY NO 21 INFORMANT Address  213-05-7856 Springfield Hospital Records  18. CAUSE OF DEATH [Enter only one couse per line for (o), (b) ond (c)]										
	1 1	DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a	Arteriosclerotic	heart disease	1.			years			
	4000	DUE TO									
		f ony, which ) (b	Generalized arte	riosclerosis.				years	1		
	gove rise to										
	lying couse lo										
	PART II.	OTHER SIGNIFICANT CON	DITIONS CONTRIBUTING TO DEATH B	UT NOT RELATED TO THE TERM	NAL DISEAS	E CONDITION GIV	EN IN PART 1	) 19 WAS	AUTOPSY DRMED?		
			cosis, psychotic 1			neumonia		YES [	] NO 🕰		
	200 ACCIDENT OR CONTRIBUTI (IF EITHER, NOT	WAS UNDERLYING  ING CAUSE OF DEATH IFY MEDICAL EXAMINER)	206. DESCRIBE HOW INJURY OCCUR	RED (Enter noture of injury in I	Port 1 or Port	t (I of item 1B )					
	20c. TIME OF IN	m 10	or 20d INJURY OCCURRED 20e- While Not while at work of work	PLACE OF INJURY (Hame, form factory, street, office bldg., etc.	, 20f (City	r or tawn)	(Cau	nty)	(State)		
	21. I certify	that I attended the	deceased from March	7 1955 , to Ja	nuary	27 19 59	that I las	saw the	deceases		

TO FUNERAL VS A15 (4) 15M 9/55 ACTUAL SIGNATURE

23. FUNERAL DIRECTOR'S SIGNATURE

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4

or attending physician.

haspital

270. BURIAL CREMATION,
PEMOVAL (Specify)
BURIAL 1-31-59

22c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery

Baltimore

ADDRESS (Street, city or town, state)

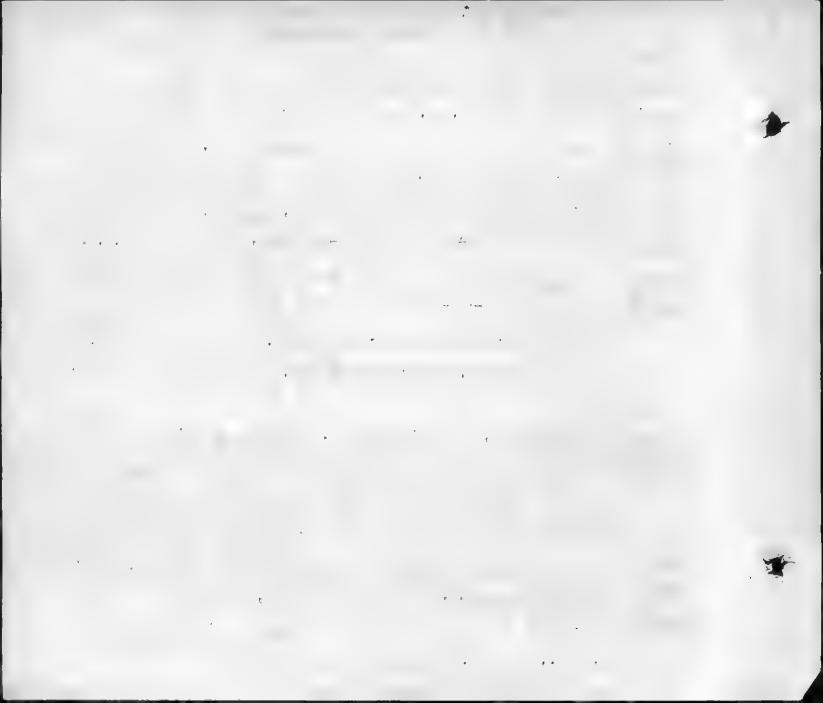
22d LOCATION (City town or county)

ADDRESS William Cook, Inc., 1217 St. Paul Street

24a REC'D BY REGISTRAR DATE JAN 3 0 '59

\_\_\_\_\_, 19.59\_\_\_\_, and that death occurred at 2:45\_PM, from the causes and an the date stated above.

246 REGISTRAR'S SIGNATURE



VS A15 [4] 15M 9/55

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death certificate be executed within 24 hours after death. Page 4	tten	ple

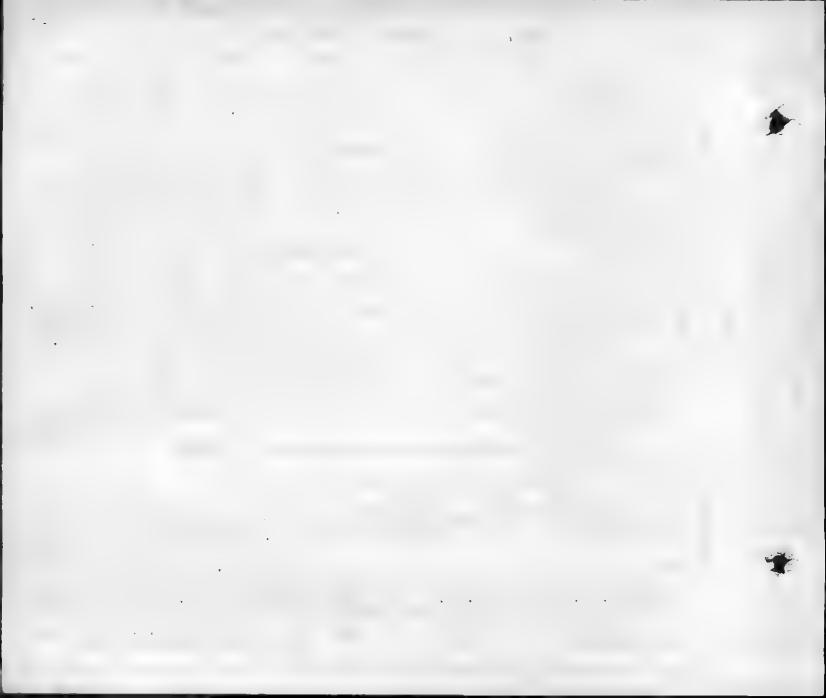
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

		4	58	CER	TIFIC.	ATI	OF DEAT	Н			R	eg. Dis		UZ	X'J
	PLACE OF DEATH COUNTY		· · · · · · · · · · · · · · · · · · ·	MA	RYLAND	2.	USUAL RESIDENCE (No. STATE Marvland	Where o	deceased	lived. If in b. COI	ofitution:	Residenc	7		ion)
		autside carporate limi	ts, write	c LENGTH OF STA	AY IN 16		CITY OR TOWN (II	Foutsid	le corpore	ote limits, w					1)
	TRESTITION  d. NAME OF HOSPITA OR INSTITUTION	( rural ) AL (If not in hospital, g				S	ilver Spri	ing			*		0.	IS RES	IDENCE FARM?
-		i State Hos	pita	1									1	res _	NO 🔀
3.	NAME OF DECEASED (Type or print)	Fir 		Paul	dle	Bu	tcher		DATE OF DEATH		Manth		Doy 17		Year 1959
5.	SEX			IEOK NEVER MAI	RRIED 🔲	B. D/	ATE OF BIRTH		1	AGE (In	years IF	UNDER		UND	R 24 HRS.
	Male	White	WIDOWE	DIVOR	CED 🔲	12	/11/05			53	ALP! W	lonths	Doys F	lours	Min
	brickla	N (Give kind of work on the life, even if refired BYOR	done 10b.	KIND OF BUSINESS	OR INDL		Maryland	1		intry)		12. CITI		WHAT	COUNTRY
13.	FATHER'S NAME					14	MOTHER'S MAIDEN	NAME	E						
	David But						Clara 1	lay	Dunn	1					
		IN U.S. ARMED FOR		SOCIAL SECURITY I	1		MANT				Address				
_	no		577	05226	58 R	eco	rd: Sprine	gfie	old S	tate	Hosp	ital			
		TH [Enter only one co	use per lir	ne for (o), (b), and (	[c).]										TWEEN
	Canditions, if an gove rise to in couse (a), stating to lying couse lost.	mediate ( DUS TO	)	lateral E			ton's Chor	rea							
CERTIFICATION		ER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO I	DEATH BU	TNOT	RELATED TO THE TER	MINAL	DISEASE	CONDITIO	N GIVEN	IN FART	- '	PERFO	RMED?
	20a. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY I	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY	OCCURR	ED (Er	iter noture of injury i	in Port I	l ar Patt	II of item 11	B.)				
MEDICAL	20c TIME OF INJURY Hour o.m. p. m.	Month, Doy, Yes	20d It While of worl	NOL while of wark	20er, Pl	LACE (	OF INJURY (Home, fo street, office bldg., e	rm, 20 rtc )	Of (City o	or fown)		(C	ounty)		(State)
	21. I certify the	at I attended the	decease	ed fram			, 19, ta			, 19	<u></u> ,t	hat Ele	ast saw	the	deceased
	ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	grieti.	(. de	ond the	of death	M.D	inred at			the caused, city or	_		e date	state Di	ed abave
220	BURIAL, CREMATION REMOVAL (Specify)	Jan. 20,	5°9	22c. NAME OF CE	METERY C	OR CRI	wtia,		Dal	ON (City, 1		Mis	MATURE	(State	*1
77	Juneah &	hartister	91	sin Fire	ecton	2,	Pa. BAHLA	0 15	REGISTR 9 '59		REGISSA.	1 02.41	Trace		



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within 24 hours



	460	CERTIFICA	AIE OF DEATH	Re	g. Dist. No.
	PLACE OF DEATH  a. COUNTY CANNOLL	MARYLAND	2. USUAL RESIDENCE (Where do o. STATE)	oceased lived. If institution, R b. COUNTY	esidence before admission)
1	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RIGH OF STAY IN 16	CITY OR TOWN (Poutside	corporate limits, write RURAS	and give-nearest town)
£	d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION	THORE	d. STREET ADDRESS	ord Mennit	e. IS RESIDENC ON A FARM YES NO
	NAME OF DECEASED (Type or print) PACHAEL ELIZ	2ABETH	CODMANN	DATE Month /	Day Year 27 14 195
5.	SEX   6. COLOR OR RACE 7. MARRIED WIDOWED &	NEVER MARRIED	8. DATE OF BIRTH 186	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	NOER 1 YEAR IF UNDER 24) hths Days Hours Mi
100	SUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (Stole or to	reign country	2. CITIZEN OF WHAT COU
13.	FATHER'S NAME		14. MOTHER'S MAIDEN NAME	200	
15. (Ye	WAS DECEASED EVER INV S ARMED FORCES? 16. SOCIA	L SECURITY NO. 17	INFORMANT S. Lett.	te West Traces	Tu Test RX
	18. CAUSE OF DEATH [Enter only one cause per line for	(a), (b), ang (c).	^	0.4	INTERVAL BETWEE
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	nalm	elarite	nosell	ONSET AND PEA
	Gave vise to immediate case (a), stating the <u>under-lying cause last.</u> (b)  DUE TO  (c)				
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTR	rene t	the least	was and	PAR (b) 19. WAS AUTO PERFORMED YES NO
	· ·	OW INJURY OCCURRI	ED. (Enter nature of injury in Port 1	or Par II of Item 18.7	
MEDICAL	20c. TIME OF INJURY Month, Doy, Year Hour a.m. 19 While at work C		LACE OF INJURY (Home, form, 20 octory, street, office bldg., etc.)	f. (City or lown)	(County) (Si
	21. I certify that I attended the deceased from alive an 1259	, and that deat	1255, to ) a	fram the causes and	at I last saw the dece
	ACTUAL PROPOSATION	Sans		E55 (Street, city or town, state)	
	PHYSICIAN'S DAE, REESE	Wilk	ens. L	redim	inster
220	G. BURIAL, CREMATION, 22b. DATE THEREOF 22c. SENOVAL (Specify)	NAME OF CEMETERY O	OR CREMATORY 22d.	LOCATION (City, town, or con	inty) (State)
23.		ADDRESS,	24 REC'D BY DATE INN		e's SIGNATURE

may be retained by the haspital or othending physician.

TO FUNERAL DIP OR: After this certificate has been signed by the othending physician and completely filled in my page 3 should by detached for use as the burial-transit permit. Then please remove carbon pagers. Pages 1 and 2 the registror prior to burial, cremation, or remayal, and in any event within 72 hours after death. TO HOSPITAL OR VS A15 (4) 15M 9/55

grerol director, id be filed with

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4



Reg. Dist. No.

	4	a. COUNTY Level b. COUNTY Stilled b. COUNTY Stilled b. COUNTY Stilled						
	t	c. CITY OR TOWN (If outside corporate limits, write RUBAL pad give nearest tawn)  RUBAL pad give nearest lawn)  SO Y W  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn)  RUBAL pad give nearest lawn)						
		d. NAME OF HOSPITAL (If not in haspitol, give street address)  OR INSTITUTION  ON A FARM?  YES   NO DE						
		NAME OF DECEASED (AROLINE - K-DENNER DEATH Julically 6 1959						
	5.5							
	100	USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country)  12. CITIZEN OF WHAT COUNTRY?  WIS A						
1	13/	estics Largeglock Not Known						
	15. (Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? TO SOCIAL SECURITY NO. W INFORMANT JUSTICE OF PATICES TO SOCIAL SECURITY NO. W INFORMANT JUSTICE OF PATICES TO SOCIAL SECURITY NO. W INFORMANT JUSTICE OF PATICES TO SOCIAL SECURITY NO. W INFORMANT JUSTICE OF PATICES TO SOCIAL SECURITY NO.						
,		18 CAUSE OF DEATH [Enter only one couse per line for (o) (b) and (c)]    PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Circle Cause Constant   Learner   Lineare    Street   100						
		Conditions, if any, which gave rise to immediate (b) Consumary Heart December 5 yes						
	7	tring couse lost. (c) Cerebural Thursonbores / y						
1	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED?  YES NO PERFORMED?						
		206 ACCIDENT WAS UNDERLYING   20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part 1 or Port II of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a. m.  p. m.  19  20d INJURY OCCURRED While Not while of work all work all work are all work.						
		21. I certify that I attended the deceased from arms, 1948, to gran 6, 1954, that I last saw the deceased alive an 1963, 1954, and that death occurred at 6044 M, from the causes and on the date stated above ADDRESS (Street, city or town, stote) / DATE SIGNED						
		SIGNATURE WITH Tround MD. MANCHESTE-Md 1-8-59						
		PHYSICIAN'S W. H-OATD M.D. MANCHESTER Md						
		BUR AL, CREMATION, 126 DATE THEREOF PLECE VALUE OF CEMETERY OR CREMATORY DECLEVATION (C by town, or country) The Country Decleved Let This						
	23 €	MINERAL DIRECTOR'S SIGNATURE  LIPTORE PILEAR MAR DATE JAN 9 39 2 than 8 thanks						

may be retained by the haspital ar attending physician.

TO FUNERAL Dr. 1908: After this certificate has been signed by the attending physician and completely filled in by "uneral director.

page 3 should as detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/55

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4



aff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



00453

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o COUNTY # b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) d. STREET ADDRESS d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? OR INSTITUTION YES NO PA 3. NAME OF 4. DATE Middle Last Month Day Year DECEASED DEATH (Type or print) 195 FUNDER 1 YEAR IF UNDER 24 WAS 5. SEX 6. COLOR OR RACE 7. MARRIED THEYER MARRIED DATE OF BIRTH AGE (In years tost birthday) Min WIDOWED | DIVORCED | 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) LA OLELIE DUE TO Conditions, if any, which ] gove rise to immediate **DUE TO** coese (o), stoting the underlying couse los! PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISPASE CONDITION GIVEN IN PART 1(0) 19. WAS ALTOPSY PERFORMED? YES NO CERTIFI 20a ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f, (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stole) factory, street, office bldg., etc.] Hour o. m. of work at wirk that I attended the deceased fram ., 1921, that I last saw the deceased and that death accurred at Till Tow, from the causes and an the date stated above. MODRESS (Street, city or Jones SIGNATURE PHYSICIAN'S NAME (Type) 22b. DATE THEREOF 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d\_LOCATION (City, fown, or county) (Stote) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 1 6 59 arthur & Kings

director offer shoul

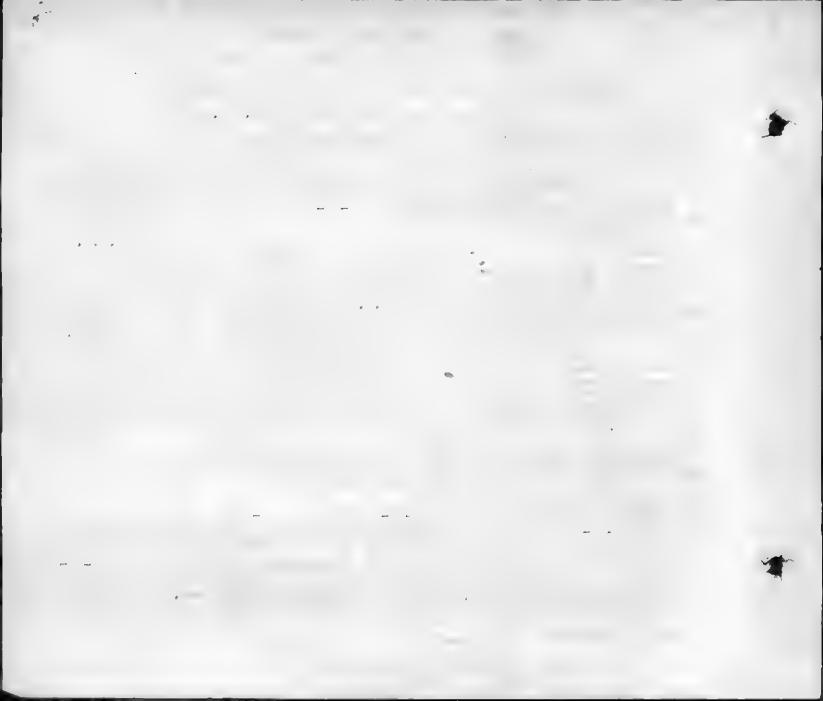


VS A15 (4) 15M 9/55

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

ACTUAL SIGNATURE ACTUAL LISTER M.D. Springfield State Hospital 1-17-59  PHYSICIAN'S NAME (Type) Edmind Insthaus M.D. Sykesville, Maryland,  220 Burial, Cremation, 22b. Date thereof Removal (Specify) Dal Limore (Stole)  Date signed M.D. Springfield State Hospital 1-17-59  22c. Name of Cemetery Or Crematory (Stole) Dal Limore (Stole)  Date signed M.D. Springfield State Hospital 1-17-59  22c. Name of Cemetery Or Crematory (Stole) Dal Limore (Stole)  Date signed M.D. Springfield State Hospital 1-17-59  22d. Local on (City, town, or county) (Stole)  Date signed M.D. Springfield State Hospital 1-17-59  22d. Local on (City, town, or county) (Stole)  Date signed M.D. Springfield State Hospital 1-17-59		463	CERTIFIC	ATE OF D	EATH		Reg. Dist. f	No.
b. CUTY OR TOWN (if outlide corporate limits, write RUBAL and give necess town)  RUBAL and give necess town)  Syrks sylle  d. NAME of the Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Middle  Syrks sylle  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Syringfield State Hospital  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosphol), give street odders)  Noty Mal (in an in hosp	1. PLACE OF DEATH			2 USUAL RESID	ENCE (Where decea		on: Residence b	efore admission)
b. CUTY OR TOWN (if ouride copporte limits, write RURAL and give necess town)  RURAL and give necess town)  Syresyrille  d. NAME of the North Act from in hosphol. give street odders)  Syringfield State Hospital  Middle  d. Syresyrille  d. State Adoress  Springfield State Hospital  North Act for years [Hundle   17   19   19    DATE STATE   17   19   19    DATE STATE   17   19   19    Syresyringfield State Hospital  North Act for years [Hundle   17   19   19    DATE STATE   10   10   10   10    DATE STATE   10	Carroll		MARYLAND		Maryland	b. COUNTY	City	V
Syrkesville  A NAME OF THE IT MODE THAT IT MODE THE THOUGHT OF THE	b. CITY OR TOWN (If outside corporate fir	mits, write c. LEI	NGTH OF STAY IN 16	c. CITY OR T	OWN (If outside car	porote limits, write R	URAL and give	nearest town)
d. NAME OF POSY TALL (IT would in begind), gore street oddress)  Springfield State Hospital  Springfield State Hospital  Springfield State Hospital  Springfield State Hospital  First  Middle  Losi  4. DATE  DOWN A BOATS  First  Month  Day  Year  10 PART OF BIRTH  SLIInghaus  9. Act (in your He Under 172 He North  10 Part Hospital  10	Svkesville	7 7	7 4 m 5 da	Vs Bal	timore 2.	Md (Baltim	ore 2)	
Springfield State Hospital   859 Mc Aleer Court   YES   NOT    NAME OF PERMANE   Middle   Bilinghaus   North   Day   Very    Springfield State Hospital   Middle   Bilinghaus   Did    Springfield State   Hospital   Did    Name of Permane   Did   Did    Springfield State   Hospital   Did    Name of Permane   Did   Did    Name of Did    Name o	OK INSTITUTION		)					
DECEASE OF DEATH [Find or print]  10. SEX    COUGN OF RACE   7. MARRIED   NEVER MARRIED   9. DATE OF BIRTH   P. AGE (In year)   1. IN 17   19 59   S. SEX   Milde   White   Windows DT DIVORCED   9. DATE OF BIRTH   OU.SJAL OCCUPATION (Cive kind of west dome lob. KIND OF BUSINESS OR INDUSTRY   11 BIRTHPLACE (Stole or foreign county)   12. CITIZEN OF WHAT COUNTRY of USALA OCCUPATION (Cive kind of west dome lob. KIND OF BUSINESS OR INDUSTRY   11 BIRTHPLACE (Stole or foreign county)   12. CITIZEN OF WHAT COUNTRY   13. FANHER'S NAME    Ja mos Field   14 MONTHE'S MAIDEN NAME   14 MONTHE'S MAIDEN NAME   14 MONTHE'S MAIDEN NAME   15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16 SOCIAL SECURITY NO.   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause per line for (a), (b), and (c)   17. INFORMANT   Address   18 monthe's maiden of west cause of line of the course (a), the line of the course of mainty in Fort I or Fort II of item 18   18 monthe course (a) mainty in Fort I or Fort II of item 18   18 monthe course (a) mainty in Fort I or Fort II of item 18   18 monthe course (a) mainty in Fort I or Fort II of item 18   18 monthe course (a) mainty in Fort I or Fort II of ite	Springfield State H	ospital		859 Mc	leer Cour	t		
3. SEX   0. COLOR OR RACE   7. MARRED   NEVER MARRIED   2. DATE OF BIRTH   9. AGG (in year)   Foundation (first band of the probability of the p	DECEASED		Middle		Of		њ 1	
Terma   S	5. SEX 6. COLOR OR RACE	7. MARRIED	NEVER MARRIED			9. AGE (In years		AR IF UNDER 24 HRS.
Description	Female White	WIDOWED 1	DIVORCED 🗍	9-18-	1880		Manihs Day	s Hours Min.
13. FATHER'S NAME	19a USJAL OCCUPATION (Give kind of world during most of working life, even if retire	dane 10b KIND (	OF BUSINESS OR IND	USTRY 11 BIRTHPL	ACE (Stole or foreign	country)	12. CITIZEN	OF WHAT COUNTRY
Ja mes Field  S. WAS DECEASEDEVER IN U. S. ARMED FORCES? The for continuous of the control of th							U.	S.A.
13 WAS DECEASEDEVER IN U.S. ARMED FORCES?   16 SOCIAL SECURITY NO.   17. INFORMANT   Address   18. CAUSE OF DEATH   Enter only one cause per line for (e), (b), and (c)   PART I. DEATH   WAS CAUSED BY   GENETALIZED   abdominal carcinomatosis   INTERVAL BETWEEN ONSEL AND DEATH   YEAR I. DEATH   WAS CAUSED BY   GENETALIZED   Abdominal carcinomatosis   ONSEL AND DEATH   YEAR II. DEATH   WAS CAUSED BY   DUE TO   Conditions, if only, which gove rise to immediate   DUE TO   Government								
The cause of Death [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) Genetalized abdominal carcinomatosis  PART I. OTHER SIGNIFICANT (COUNTY)  Conditions, if only, which gove rise to immediate course (b), stoling the under-tying couse lost.  (c)  Senile psychoolis with part model lost tures, Positive serological reaction  To syphilis  OR ACCIDENT WAS JUNCENTING.  To contistuting a cause of bath part model lost tures, Positive serological reaction  OR Contistuting a cause of bath part model. (County)  To contistuting a cause of bath part model lost tures, Positive serological reaction  To contistuting a cause of bath part model. (County)  To accident was undertwing.  To contistuting a cause of bath part model lost tures, Positive serological reaction  OR Contistuting a cause of bath part model. (County)  To contistuting a cause of bath part model lost tures, Positive serological reaction  To contistuting a cause of bath part model lost tures, Positive serological reaction  To contiste the model of the mo					zabeth Leh			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), ond (c)]  PART I. DEATH WAS CAUSED BY [MMEDIATE CAUSE (c)]  DUE TO  Conditions, if only, which gove rine it only, which gove rine to immediate pound of the cause (c), it oling the under the under the under the cause (c), it oling the under the un	15 WAS DECEASED EVER IN U. S. ARMED FO	RCES? 16 SOCIAI					ress	
PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (s) Generalized abdominal carcinomatosis  ONSET AND DEATH YEARS  ONSET AND DEATH  YEARS  ONSET AND  O				S.S.Hospi	tal Record	s		
DUE TO  Cenditions, if ony, which gove rise to immediate cause (o), stoling the under-tying couse lost.  (c)  Senil Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NOT 100 ACCIDENT WAS JNDERSYING 1 OZO BEATH 11 EITHER NOTIFY MEDICAL EXAMINER)  200 ACCIDENT WAS JNDERSYING 1 OZO DEATH 11 OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NOT 100 ACCIDENT WAS JNDERSYING 1 OZO ACCIDENT WAS JNDERSY JND						•	i c	NTERVAL BETWEEN
gove rise to immediate cause (a), storing the under- tying couse lost.  (c)  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  PERFORMED?  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II of item 18.)  200. ACCIDENT WAS JUNDERLY OCCURRED. (City or Injury in Port I or Port II or Injury in Port I or Port	IMMEDIATE CAUSE	·	Lized abou	ominal car	rc1nomatos	15		years
Cause (o), stoling the under-tying course lost.    Columbia   Colu		(b)						
Sying couse lost.   (c)		0						
TOT SUPPLIES  200 ACCIDENT WAS JNDREYING 200 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of idem 18)  200 ACCIDENT WAS JNDREY MEDICAL EXAMINER)  200 TIME OF INJURY Manth, Day, Year 200 INJURY OCCURRED While Not while foctory, street, office bldg., etc.)  200 TIME OF INJURY Manth, Day, Year 200 INJURY OCCURRED While Not work of work foctory, street, office bldg., etc.)  21 I certify that I attended the deceased fram 10-20- 19.54, to 1-17- 19.59 that I last saw the deceased alive on 1-17- 19.59 and that death accurred at 11 A M, fram the causes and an the date stated above ADDRESS (Street, city or fown, stele)  220 BURIAL CREMATION, 22b. DATE THEREOF ROW N.D. Sykesville, Maryland.  230 BURIAL CREMATION, 22b. DATE THEREOF ROW N.D. Sykesville, Maryland.  231 Sykesville, Maryland.  232 BURIAL CREMATION, 22b. DATE THEREOF ROW N.D. Sykesville, Maryland.  232 BURIAL CREMATION, 22b. DATE THEREOF ROW N.D. Sykesville, Maryland.  233 GCAI ON [City, town, or county) (Stole)  234 GCAI ON [City, town, or county) DALL LIMOTE  234 BURIAL CREMATION ON TANK OF CEMETERY OR CREMATORY DALL LIMOTE  245 FLYREAL DIRECTOR'S SIGNATURE	lying couse lost.							
20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED Have a.m., P. m. 19 While of work of work of work of work of work of work alive an 1-17- 19.59, that I last saw the deceased alive an 1-17- 19.59, and that death accurred at 11 A.M. from the causes and an the date stated above ADDRESS (Street, city or town, stele)  ACTUAL SIGNATURE ADDRESS (Street, city or town, stele)  PHYSICIAN'S NAME (Type) Ediminal Instibutes M.D.  Sykesville, Maryland, Removal (Remation, 27b. Date Thereof Hourt armed Cemetery or Crematory Delicity (Stole)  Delicity of Ediminal Instibutes M.D.  20c PURIAL (CREMATION, 27b. DATE THEREOF HOURT CEMETERY OR CREMATORY Delicity)  Delicity of Ediminal Instibutes M.D.  21d. (Caunty) (City or town) (Caunty) (Stole)  DATE SIGNATURE  22d. (CAI ON (City, town, or county) (Stole)  Delicity of Ediminal Institutes ADDRESS (Street, city or town, or county) (Stole)  Delicity of Ediminal Institutes ADDRESS (Street, city or town, or county) (Stole)	3 for syphilis	CAN EM	d Teature	a, Positive	serologi	CEL TORCE	ION PART 160	19. WAS AUTOPSY PERFORMED? YES NO
21. I certify that I attended the deceased fram 10-20- 19.54, to 1-17- 19.59 that I last saw the deceased alive an 1-17- 19.59 and that death accurred at 11 A. M. fram the causes and an the date stated above ADDRESS (Sireet, city or town, state)  ACTUAL SIGNATURE ADDRESS (Sireet, city or town, state)  DATE SIGNED ACTUAL SIGNATURE  M.D. Springfield State Hospital 1-17- 59  PHYSICIAN'S NAME (Type) Edimind Insthaus M.D.  Sykesville, Maryland,  REMOVAL (Specify) PALITIMOTE  DELITIMOTE  220. NAME OF CEMETERY OF CREMATORY DELITIMOTE  231 LOCAL ON (City, town, or county) DELITIMOTE  232 FLYPERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 240. REGISTRAR'S SIGNATURE		206. DESCRIBE H	OW INJURY OCCUR	RED. (Enter nature al	injury in Port I or Po	ort II of item 18)		
21. I certify that I attended the deceased fram 10-20- 19.54, to 1-17- 19.59 that I last saw the deceased alive an 1-17- 19.59 and that death accurred at 11 A. M. fram the causes and an the date stated above ADDRESS (Sireet, city or town, state)  ACTUAL SIGNATURE ADDRESS (Sireet, city or town, state)  DATE SIGNED ACTUAL SIGNATURE  M.D. Springfield State Hospital 1-17- 59  PHYSICIAN'S NAME (Type) Edimind Insthaus M.D.  Sykesville, Maryland,  REMOVAL (Specify) PALITIMOTE  DELITIMOTE  220. NAME OF CEMETERY OF CREMATORY DELITIMOTE  231 LOCAL ON (City, town, or county) DELITIMOTE  232 FLYPERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 240. REGISTRAR'S SIGNATURE	20c. TIME OF INJURY Manth, Day, Y Hour a.m.	While N	lot while	PLACE OF INJURY (Foctory, street, office	lome, form, 20/ (Ci bldg., etc.)	ity ar tawn)	(Coun	ty) (State)
alive an 1-17-  19 59 , and that death accurred at 11 A M, from the causes and an the date stated above  ACTUAL SIGNATURE ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE ADDRESS (Street, city or town, state)  ACTUAL M.D. Springfield State Hospital 1-17-59  PHYSICIAN'S NAME (Type) Edimind Insthaus M.D. Sykesville, Maryland,  220 BURIAL CREMATION, 22b. DATE THEREOF MOUNT CREMATORY REMOVAL CREMATORY DELIMINATE  22c. NAME OF CEMETERY OF CREMATORY DELIMINATE  22d. LOCAL ON (City, Town, or county) (Stole)  DATE SIGNATURE  22d. LOCAL ON (City, Town, or county) DELIMINATE  22d. LOCAL ON (City, Town, or county) DELIMINATE  22d. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			30.00	51	7_75	250		
ACTUAL SIGNATURE ACTUAL LISTER M.D. Springfield State Hospital 1-17-59  PHYSICIAN'S NAME (Type) Edmind Insthaus M.D. Sykesville, Maryland,  220 Burial, Cremation, 22b. Date thereof Removal (Specify) Dallimore (Stole)  Date signet M.D. Springfield State Hospital 1-17-59  22c. Name of Cemetery Or Crematory (Stole) Dallimore (Stole)  Dallimore (Stole)  23c. Name of Cemetery Or Crematory Dallimore (Stole)  Dallimore (Stole)  23d. Record by Registrar 24b. Registrar's Signature	9 9/9							
ACTUAL SIGNATURE CANCER SUCCESSIONATURE  ACTUAL SIGNATURE CANCER SIGNATURE  M.D. Springfield State Hospital 1-17-59  PHYSICIAN'S NAME (Type) Edmind Insthans M.D. Sykesville, Maryland,  Sykesville, Maryland,  Sykesville, Maryland,  120. LOCAL ON (City, lown, or county)  Deliniel January 20 /57  220. REC'D BY REGISTRAR'S SIGNATURE  240. REC'D BY REGISTRAR'S SIGNATURE	affive an	19	_, and that deal	h accurred at:				
PHYSICIAN'S NAME (Type) Edimind Insthaus M.D.  20 BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY REMOVAL (Specify) Dount Carried Cemetery Daltimore (Stole)  21 Supplied January 20 /65  22 Address 24c. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	ACTUAL TOTAL	Tis	There	C. C.				
NAME (Type) Edimind Listhaus M.D.  Sykesville, Maryland,  20 BURIAL, CREMATION, REMOVAL (Specify)  Dhunial January 20 /51  32 Fuyeral Director's SIGNATURE  ADDRESS  Sykesville, Maryland,  22d. Local On (City, lown, or county)  Baltimore  22d. Local On (City, lown, or county)  Baltimore  24d. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	SIGNATURE CO	0000		_w.p <del>12</del>	iBriand Bi	Wea Hoabi	PRIT	7-7(- 52
buriel January 20 /51  23 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	NAME (Type) Edmind List							
23 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR'S SIGNATURE	REMOVAL (Specify)		NAME OF CEMETERY	el Cemete:	ry 22d. toc	A chicor town.	or county)	(Stole)
1133 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	23 FUNERAL DIRECTOR'S SIGNATURE	' A			24o. REC'D BY REGI	STRAR 24b. REGIS	TRAR'S SIGNA	TURE
Ullrich Funeral Home 4210 Belair Road DATE JAN 21 '59 Collan & Frank	Ullrich Funeral He	ome 4210	Belair Ros	a	DATE JAN 21	'59 .	Thun S. Fr	aus.

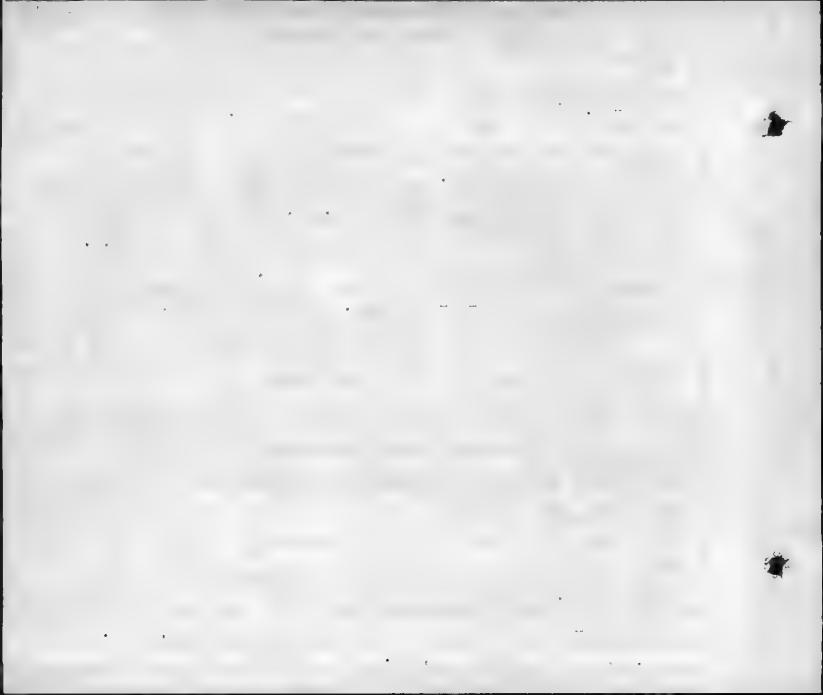


VS A15 (4) 15M 9/55

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

LCZ. CEPTIEICATE OF DEATH

305	CERTIFICA	CIL OF BLATTI	Reg. Dis	t. No.
1. PLACE OF DEATH 0. COUNTY C rroll	MARYLAND	2 USUAL RESIDENCE (Where decear a. STATE	ed lived If institution: Resident	te before admission)
b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest fown)	Life	c. CITY OR TOWN (If outside corp.  X Rurol Lit		ive nearest town)
d. NAME OF HOSPITAL (If not in hospital, give struction)	eet oddress)	, d. STREET ADDRESS Gillis Ro		IS RESIDENCE     ON A FARM?     YES    NO
3. NAME OF FIRST DECEASED (Type or print) RUDY	Middle PL	Lost 4. DATE OF DEATH	Month	Day Year 12 1959
nale white woo	OWED DIVORCED	Nov. 21, 1915	last birthday) Months	YEAR IF UNDER 24 HRS. Days Hours Min
USUAL OCCUPATION (Give kind of work done 1 during most of warking life, even if retired)  Farmer	Ob. KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (State or foreign Maryland		ZEN OF WHAT COUNTR
3. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Otho Augustus	Fleming	Elsie G. G	unn	
S. WAS DECEASED EVER IN U. S. ARMED FORCES? (You no or unknown)  NO  [If you, give war or dates of service)		FORMANT Ars. Catherine	Address Fleraing, Sa	ne
PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  14 20 s  DUE TO  Conditions, if ony, which gove rise to immediate cause (a), stating the under lying cause last.  (c)	Cure Colona	lerosis		2 years
PART II. OTHER SIGNIFICANT CONDITION  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH OF (IF EITHER, NOTIFY MEDICAL EXAMINER)	1(a) 19. WAS AUTOPSY PERFORMED? YES NO			
20c. TIME OF INJURY Manth, Day, Year 20c	i. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, form, 20f. (Citory, street, office bldg., etc.)	y or town) (C	ounty) (State)
21. I certify that I offended the dece olive on	sulwell,	occurred at 65 A.M. fro	m the couses and on the Street, city or town, store)  Bury, Md	e date stated above DATE SIGNI
PHYSICIAN'S NAME (Type) IV . D. CITL V.	22c. NAME OF CEMETERY OF	COCHATORY	TANK (Ch. A.	
REMOVAL (Specify) 1-15-1959	Taylorsv		TOLL CO. L.	(State)



VS A15 (4) 15M 10/57

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physician a	remove carbo
he attending	Then please

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 465

**CERTIFICATE OF DEATH** 

Ren. Dist. No.

00456

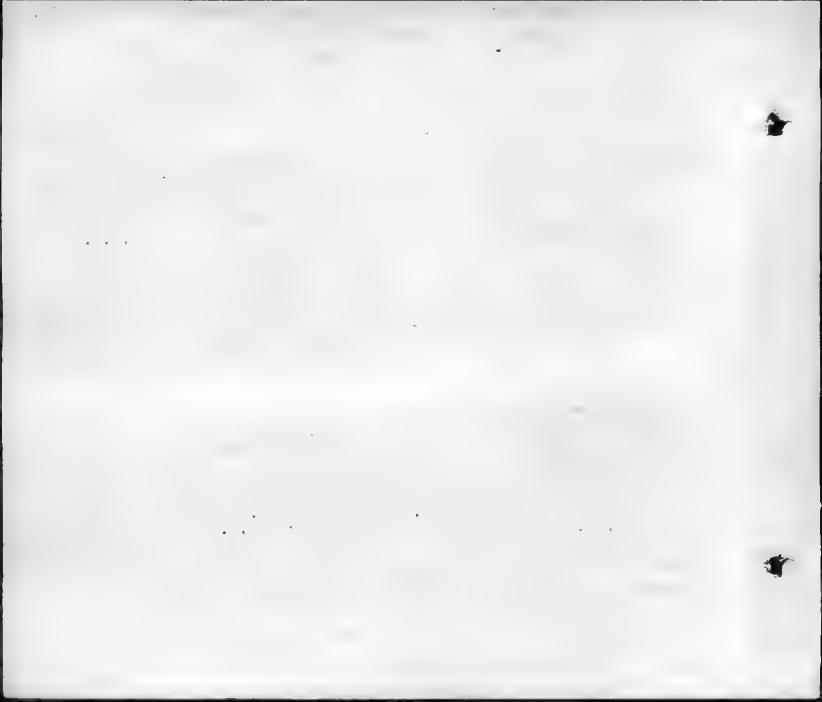
	arroll (If outside corporate limits,	MARYLAN		Where deceased lived. If institution: Resid	rence detate damission)
b CITY OR TOWN RURAL and give	(If outside corporate limits,		Maryland	b. COUNTY	71.
	ytown - Rur			autside corporate limits, write RURAL and	d give nearest town)
d NAME OF HOSP OR INSTITUTION	ITAL (If nat in haspital, give	street oddress)	d. street Address Rural		e. IS RESIDENCE ON A FARM? YES NO
3 NAME OF DECEASED (Type or print)	Mary	Middle	Ford	4. DATE Month OF DEATH January	Doy Yeor V <b>25</b> 19 69
5. SEX Female		MARRIED NEVER MARRIED DIVORCED		9 AGE (In years If UND)	ER TYEAR IF UNDER 24 HRS
100 USUAL OCCUPAT	ION (Give kind of work don rking life, even if retired)	school teacher	DUSTRY 11. BIRTHPLACE (Slot		CITIZEN OF WHAT COUNTRY
John T.	Ford		14. MOTHER'S MAIDEN Hester	R. Welby	
	ER IN U. S. ARMED FORCES (If yes, give wor or dates of service		informant irs. Helen Osbo	orn 6123 Colburn Av	Ind.
Conditions, if gove rise to couse (a), stoting lying couse lost	immediate DUE TO	arterioscle	rossis & se	welity	5 days
PART II OT	HER SIGNIFICANT CONDIT	ONS CONTRIBUTING TO DEATH	BUT NOT RELATED TO THE TERA	MINAL DISEASE CONDITION GIVEN IN PA	ART I(a) 19 WAS AUTOPSY PERFORMED? YES NO X
U (IF EITHER, NOTIF	AS UNDERLYING 201 G CAUSE OF DEATH Y MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	RRED. (Enter noture of injury in	Part I or Port II of ilem 18 ]	
20c. TIME OF INJU Hour o. m. p. m.		20d. INJURY OCCURRED 20e While Not while of work 0 of work	PLACE OF INJURY (Home, for foctory, street, office bldg., et	m, 20f (City or town)	(County) (State)
21. I certify to alive an	hat I attended the de an 24 harles R	50 0		An 25, 1959, that M, fram the causes and on ADDRESS (Sireet, city or town, stote) with hung Men	I last saw the deceased the date stated above DATE SIGNED
PHYSICIAN'S NAME (Type)	haples A				



filled in by funeral director, ages I and 2 should be fired with

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5	FUN Age
10	may be retained by the haspital or attending physician.  TO FUNERAL Discription of the haspital or attending physician.  TO FUNERAL Discription of the his certificate has been signed by the attending physician and campletely filled in by the fired director.  Page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be fired with the registrar prior to burial, cremation, ar remaval, and in any event within 72 harfs after death.
Y	5 A1S (4) 5M 9/5S

		300		CERTIFICATE OF DEATH			•	Reg. Dist. No.					
Г	I, PLACE OF DEATH				2	USUAL RESID	ENCE (Wh	ere decease	d lived If instituti		befare a	dmissio	n)
Ł	Carroll MARYLAND				D	Maryland b. COUNTY Garrett 132						}	
	b. CITY OR TOWN (RURAL ond, give_n	If outside corporate limi	ts, write	c. LENGTH OF STAY IN 1	ь	c CITY OR TO	OWN (IF or	(If outside carporate limits, write RURAL and give nearest tawn)					
-	Sykesvill	.e		6yrs10mos		Accide	ent		1		•		
. [	d NAME OF HOSPI	TAL (If not in hospital, s	ive street	address)		d. STREET AD	DRESS				0. 1	S RESID	ENCE
	Springfie	1d State	Hosp	ital		132						ES 🔂	
	3. NAME OF DECEASED	fic	rs†	Middle		Lost		4. DATE OF	Mor	ıth.	Day	Ye	or
	(Type or print)	Clarence	Henr	J		Foy		DEATH	Jan.	. 1.	1	19	59
	5. SEX	6. COLOR OR RACE	7. MARE	IED NEVER MARRIED	] B D	ATE OF BIRTH			9. AGE (In years lost birthday)	Months C			The second second
L	male	white	WIDOW			an 13			80 yr	Months	Days H	0011	Min
-	10a. USUAL OCCUPATION  during most of wor	ON (Give kind of work king life, even if retired	dane 10b	KIND OF BUSINESS OR IN	DUSTRY	11 BIRTHPLA	CE (State o	or fareign c	ountry)	12. CITIZ	ZEN OF V	VHAT C	OUNTRY?
	Farmer					Mary.	land			U.	S.A.		
	13. FATHER'S NAME				1.	4 MOTHER'S	MAIDEN N	AME					
L		John Fo	У			Mar	tha	Bulte	r				
-1	15. WAS DECEASED EVE (Yes. no. or unknown)	R IN U. S. ARMED FOR			INFO				Add				
Ĺ	unknown	unknown		unknown	Rec	ords o	of S	pring	field S	state	Hos	pit	al
		ATH [Enler only one co									INTERV		
1	PART I, DE/	ATH WAS CAUSED BY: IMMEDIATE CAUSE (c	, Cer	ebral Hemo	rrh	age					24	hr	S
ł		/ DUE TO									pore	th	an
1	Conditions, if o		Art	eriosclero	tic	Card:	Lovas	scule	r Disea	ase	10	yrs	
1	gove rise la cause (o), sloting												
1	lying couse lost	) (c	)								<u> </u>		
ı	Chronic	HERESTERNE CONT. COS	er co	MO TO CASIVA COM	ned	KANATER TO	THE TERM	SAULUIS DAS	DOMESTICON TO I	EN IN PART	1(0) 19. 1	WAS AU	AED?
	Merapol			ion with S						1 psy	chot	ইব্ৰ	NO X
- 1		AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCUI	RED. (E	nter noture of	injury in P	orl I or The	action				•
-		Y Month, Day, Ye			PLACE	OF INJURY (H	ame, form,	20f. (City	or town)	(Cc	ounty)		(State)
1	Hour e.m.	Į9	While at war	Not while	rusiury.	, 211441, 011164	andgo with	<b>'</b>					
1	21. I certify th	at I attended the	deceas	ed from Aug. I	19	55,	10 38	an. 1	.L 1959	,that I la	nst saw	the d	ecensed
1	glive on Jan	.10,	12.5	9 , and that dec	th oc	curred at	LO:08	MARIN	The causes				
1		dotta	//					DDRESS (S	treet, city or town,	state)	o daic .	DAT	E SIGNED
1	ACTUAL C	valle 1	w	1/1/A	M D	Sprir	ngfie	eld S	tate Ho	spite	al,1	-11	-59
1	BUVEICIANIE												
	PHYSICIAN'S NAME (Type)	Walter Kn	opp			Sykes	vil.	le , Ma	ryland				
	220 BUR AL, CREMAT C REMOVAL (Specify)		)F	22c NAME OF CEMETERY	OR CR	EMATORY		22d. LOCA	TION (City, tawn,	or county)		(Stale)	
	burial	1/14/5	j	Saint Faul	15	Dutie	ויייי	1 CC L	nent	War , ,			
	29 FUNERAL DIRECTOR			ADDRESS			240. REC'E			STRAR'S SIGI			
	- T - 11 1	·LTrinch	U 1.	I na istiya	- (		DATE	1 6 5	9 Ch	thun 8 t	trans		



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467

CERTIFICATE OF DEATH

		301	O L KI II I C		Reg. D	ist. No.
	1, 1	PLACE OF DEATH O. COUNTY		2. USUAL RESIDENCE (Who	re deceased lived If institutioni Reside	nce before admission)
	•	CAPPO//	MARYLAND	may.	Parish b COUNTY Con	rull
	ı	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 16	CITY OR TOWN (IF 96	tside corporate limits, write RURAL and	give nearest town)
		Westminster Gual	374ens	Wish	muster Ru	wh
	1	d. NAME OF HOSPITAL (If not in hospital, give street oddr. OR INSTITUTION)	Pas)	Marchester -	Westmenter Re	IS RESIDENCE ON A FARM? YES NO
	(	NAME OF DECEASED (Type or print)	Arddle	lost	4. DATE Month OF DEATH	Day Yeor
		70000	NEVER MARRIED	B DATE OF BIRTH	7 7 7 7 7 7	16 19J 7
	0	Female white WIDOWED [		January 271	89 dist birthday) Months	Doys Hours Min
7	100	during most of working life, even / retired)	OF BUSINESS OR INDU	JSTRY 11 BIRTHIP ACE (Stote o	r foreign country) 12. CI	TIZEN OF WHAT COUNTRY?
4	13.	FATHER'S NAME	- v	14 MOTHER'S MAIDEN NA	AME	213111
200		John Hospelds		Ellew U	land.	
	15/	WAS DECEASED EVER IN U. S ARMED FORCES? 16 SOC	IAL SECURITY NO. 17	Serbert For	och molinice	tu hed Rott.
		18. CAUSE OF DEATH [Enter only one couse per line to	r (0) (b), and (c).]			INTERVAL BETWEEN
		PART I. DEATH WAS CAUSED BY.	Kronie	myornet	etis.	ONSET, AND DEATH
		DUE TO	1	0' 1 10		7
		Conditions, if ony, which ) (by they for	decene !	nedis - Vacs	dudesin	•
		gove rise to immediate Couse (a), stating the under-				
	_	lying couse lost. (c)				
	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONT	RIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMIN	IAL DISEASE CONDITION GIVEN IN PAI	PERFORMED?
	FICA	Central	Henry	hoge - d	Dee 9:1958	YES NO
	CERTIFICATION	200 ACCIDENT WAS UNDERLYING (20b. DESCRIBE OR CONTRIBUTING (20b) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	HOW INJURY OCCURRE	ED Conter nature of injury in Pa	ort I or Port II of item 18 }	
	EDICAL		t-	ACE OF INJURY (Home, form, scrory, street, office bldg , etc.)	20f (City or town)	County) (Stole)
	Q3	Hovr a, m 10 at work 1	Not white	Alory, meet, orace Blog, etc.,		
		21. I certify that I attended the deceased f	rom NOV4	19/9/1740 20	www. 16, 1854, that I	last saw the deceased
		alive an January 12 , 19-1	and that deatl	h accurred at 21 41 1	M, fram the causes and an t	he date stated above.
		11/16/6	7 /	18 *	DDRESS (Sireel, city or town, stote)	DATE SIGNED
		SIGNATURE SIGNATURE	Lush	M.O. Sam	Selead Mey	med 1/16/57
/		PHYSICIAN'S NAME (Type) / OSEP / E. 13	BUSh INI	1/Am	pst EAD Ma	ryland
	220	BUR ALL CREMATION, 226. DATE THEREOF	. NAME OF CEMETERY C	OR CREMATORY	22d LOCATION (City, town, or county)	(Stote)
		Sithal 1/19/09 1	Uneldola	amelers	Manchaeler 11	Mushed
	23	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	4	BY REGISTRAR 246. REGISTRAR'S SI	€*
	1	1-2 /ME/12/12/11/11	of punol	DATE JA	N 1 9 '59 Cothur .	Trans

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIT FOR. After this certificate has been signed by the attending physician and completely filled in by function director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 model be ATEC with the registrar prior to burial, cremation, at removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/SS



## 468 **CERTIFICATE OF DEATH** Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY a STATE b. COUNTY MARYLAND Maruland Carro CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) RURAL and give nearest town) llivniling 17 ic. s Baltimore 31. Maryland Solosville d. NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Springfield State Hospital 734 S. Bond Street NAME OF 4. DATE Middle Froeh Tich) Month Year OF DEATH (Type or print) Froelich Connad 1959 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 5. SEX 9. AGE (In years B. DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS lost birthday) Mantha Days 7-27-90 White WIDOWED [ DIVORCED | 10a. USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Stationary Engineer O Marwland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Annie Ompton Charles Froelich 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANI Address Records of Springfield State Hospital modernom Yes. unk own 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Acute and chronic myocardial infarction Months IMMEDIATE CAUSE (a) 40,0111 DUE TO Coronary arteriosclerosis Years Conditions, if ony, which gave rise to immediate **DUE TO** couse (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS PERFORMED? Schizophrenic reaction, remobile type. YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20f (City or town) (County) (State) factory, street, affice bldg., etc.) Hour a.m Nat while at wark at wark 12 50 2 , and that death accurred at 8:00 M, from the causes and an the date stated above. alive on Jan 128. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital ACTUAL SIGNATURE PHYSICIAN'S Walter Knopp, M.D. Sykerville, Pryland NAME (Type) 22d tOCATION (City, town, or county) 22g. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY (State) Burial Frederick Rd. Md. Balto. National Fah. 2. 59 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246 REGISTRAR'S SIGNATURE 24a REC'D BY REGISTRAR JOHN J. DUDA 7922 Wise Ave. 22. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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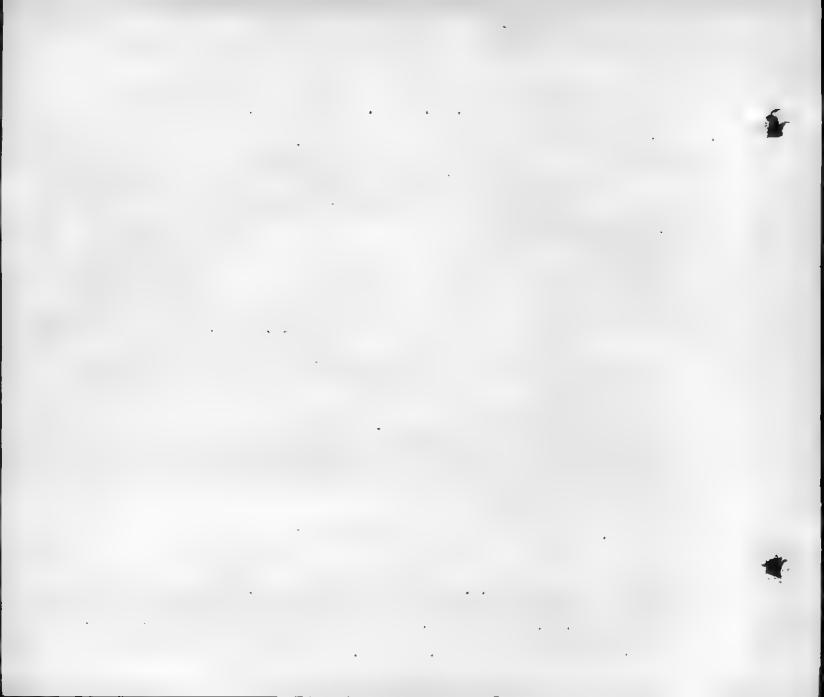
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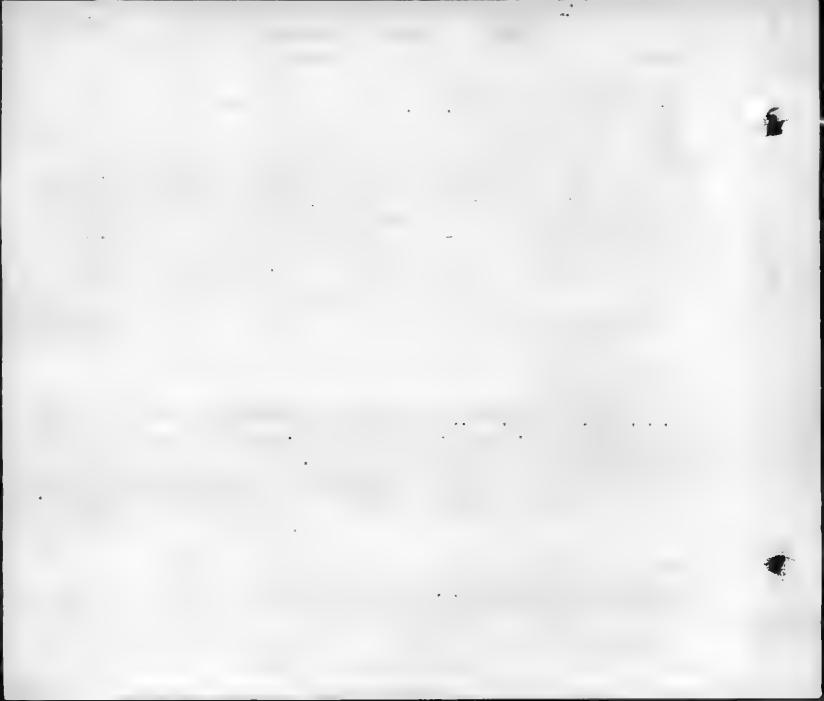
ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1	8
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469 CERTIFICATE OF DEATH

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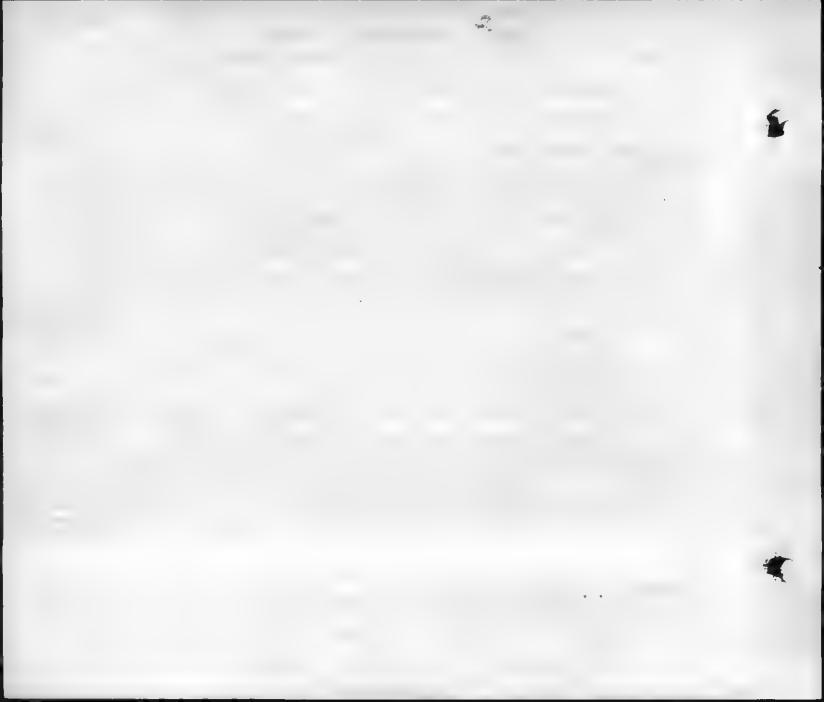
PARCE OF DEATH   C. COUNTY   CAPTOIL   MARYLAND   2 STATE   Maryland   D. COUNTY   Frederick   1 STATE   D. COUNTY   T.									MARI DIS	, ,,,,,,	
Sykesylle  d. NAME OF HOSPITAL (I POOR INDUSTRY)  d. STEET ADDRESS  D. S. SER  D. S. SER  D. S. SER  D. S. C. COLOGO & RACE   MARRIED   NOVER	a. COUNTY	arroll	MARYL	AND	2 USUAL RESID a STATE				-		_
d. NAME OF HOSPITAL (If not in hospital) give street address)  Springfield State Hospital None  1. Liella Victoria Kefauver Gaver Springfield State Hospital  3. NAME OF COLOR OR RACE 7 MARKED NORCED NOORCED May 21, 1874  3. Liella Victoria Kefauver Gaver Springfield State Hospital  3. NAME OF COLOR OR RACE 7 MARKED NOORCED N	RURAL and give n	eorest lown)							IRAL and gi	ive negrest	town)
DECARD DIPLOM COLOR RACE   7 MARRIED   NEVER MARRIED   8 DATE OF BIRTH   9. AGE (In. peac.	d, NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital, give str	eet address)							1 0	ON A FARM?
100. USAJA OCCUPATION (Give kind of work done)   100. KIND OF BUSINESS OR INDUSTRY   Indiana   12. CITIZEN OF WHAT COUNTRY   Indiana   12. CITIZEN OF WHAT COUNTRY   Indiana   12. CITIZEN OF WHAT COUNTRY   Indiana   13. FATHER'S NAME   Indiana   14. MOTHER'S MAIDEN NAME   Mary C. Glessner   15. WAS DECEASEDEVER IN U. S. ARMED FORCESS   16. SOCIAL SECURITY NO.   17. INFORMANT   Mary C. Glessner   15. WAS DECEASEDEVER IN U. S. ARMED FORCESS   16. SOCIAL SECURITY NO.   17. INFORMANT   Mary C. Glessner   16. Mother of the state of the	DECEASED			Kefa	auver Ga		OF			0oy 7.	
Indiana   U.S.A.	_	7.737.1						AGE (In years lost birthday)			
Horathia Kefauver  15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Springfield Hospital Records  16. PART I, DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (b). Bronchopneumonia IMMEDIATE CAUSE (c). Bronchopneumonia IMMEDIATE (c). Conditions, if any, which gave rise to immediate couse (a), tating the under the couse (a), tating the couse (a), t	during most of wor	king life, even if retired)	06. KIND OF BUSINESS OR	INDUST			or foreign cour	ifry)	12. CITI		
Springfield Hospital Records   Interval Between   Interval Betwe	13. FATHER'S NAME TO HO	rathia Kefauv	er		1			ner			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  POUR TO  Conditions, if any, which gave rise to immediate cause (a): It could not not be to the course of	15 WAS DECEASED EVE		16. SOCIAL SECURITY NO.			eld H	ospital				
gove rise to immediate cause (a), stating the under lying couse last.  C. Bashoc. With Circumstance of left femur.  Described in Constitution of the country		TH WAS CAUSED BY: IMMEDIATE CAUSE (0)		nia						ONSET .	AND DEATH
DSychotic reaction. Fracture, neck of left femur.  200 ACCIDENT WAS UNDERLYING BY OR CONTRIBUT NO CAUSE OF DEATH OF CONTRIBUT NO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Slipped on floor and fell.  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Software of injury in Port I or Part II of item 18)  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Slipped on floor and fell.  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Software of injury in Port I or Part II of item 18)  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Slipped on floor and fell.  200 TIME OF INJURY Month, Day, Year 200 INJURY OCCURRED Slipped on floor and fell.  21. I certify that I attended the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased alive an January 7, and that death accurred at 11:05AM, from the causes and an the date stated above ADDRESS (Street, city or town, stole)  21. I certify that I attended the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased alive an January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/59, 19 , to January 7, 19 59 that I last sow the deceased from 6/13/55, 19 , to January 7, 19 59 that I last sow the decea	gave rise to i cause (a), stating lying cause last.	mmediate DUE TO									
20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, form, factory, street, affice bldg, atc.)  7: IM p m 9/16/ 1958 While at work of work	c.g.s.as	ic reaction. I	racture, neck	of	left fer	mur .			N IN PART		
21. I certify that I attended the deceased from 6/13/55, 19, to January 7, 19, 59, that I last saw the deceased alive an January 7, 19, 59, and that death accurred at 11:05AM, from the causes and an the date stated above ADDRESS (Street, city or town, stote)  ACTUAL SIGNATURE ACCURATE ACCURATION Springfield State Hospital 1/7/59  PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland  220. BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, Town, or county) (State)  REPOYAL (Specify) 1/0/1059 Reformed Cemetery Middletown 11d.  23. FUNERAL DIRECTOR'S SIGNATURE 24b REGISTRAR'S SIGNATURE		AS UNDERLYING (1) 206 (1) CAUSE OF DEATH MEDICAL EXAMINER)					ort I ar Part II	of item 18 )			
alive an January 7, 1959 and that death accurred at 11:05AM, from the causes and an the date stated above ADDRESS (Street, city or town, stote)  ACTUAL SIGNATURE CALLILLES THE SIGNATURE  PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland  220. BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) Reformed Cemetery Middletown 11d.  23. FUNERAL DIRECTOR'S SIGNATURE  240 REC'D BY REGISTRAR'S SIGNATURE	7: PM 9 m		d INJURY OCCURRED  hile Not while wark at work	Oe. PLA	CE OF INJURY IN ORY, street, office OSPI, Ca. 1	ome, farm, bldg , atc.	20f (City or Syk				
PAME (Type) Edmund Lusthaus, 14.0. Sykesville, Maryland  220. Burial, Cremation, 22b. Date Thereof Removal (Specify) 22c Name of Cemetery or Crematory 22d Location (City, Town, or County) (Stote)  Removal (Specify) 1/0/1050 Reformed Cemetery Middletown IId.  23. Funeral Director's Signature 24b Registrar's Signature		nuary 7,	959, and that a	death	accurred at_	11:05	AM, fram   NDORESS (Street	the causes ar	nd an th		stated above
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<u> </u>		Keg, Dist, No.
	PLACE OF DEATH COUNTY HELLOW MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o 57474  Aux Could b COUNTY Left Mal
	b. CITY OR TOWN (If autside carporate limits, write C LENGTH OF STAY IN 1b RURAL and give nearest town)	c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)
L	Germount 3 yes	X Treemount
L	d. NAME OF HÖSPITÄL (If not in hospital, give street oddress) / OR INSTITUTION	d STREET ADDRESS  o. 15 RESIDENCE  NO A FARM?  VES NO RESIDENCE  NO RESIDENCE  NO RESIDENCE  NO RESIDENCE
3.	NAME OF DECEASED (Type or print) OS WALD - C - GE	OPG SEATH STELL 12 1959
5.	SEX    6. COLOR OR RACE   7 MARRIED     NEVER MARRIED	B DATE OF BIRTH  AGE (In years If UNDER 1 YEAR IF UNDER 24 ARS)  Open 4-190 F ST yrs  Manihs Doys Haurs Min
100	b. USUAL OCCUPATION (Give kind of work done of the string most of working life reven if retired)	STRY 11 BIRTHPLACE (State or Joreign country) 12. CITIZEN OF WHAT COUNTRY?
13.	FATHER'S NAME	Bubare Weber
	WAS DECEASED EVER IN U. 5 ARMED FORCES? IN SOCIAL SECURITY NO. 17. I	9 - Mrs Eswald Leve- Lewenners To
	18. CAUSE OF DEATH [Enter only one cause per lune for (o), (b), and (c) ]	-D INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Throng ONSET AND DEATH
	420.1 DUE TO	
	Conditions, if any, which gave rise to immediate (b)	
	cause (a), stating the under ( DUL TO	
Z	lying cause lost. (c)	
ICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO 1
L CERTIF	206 ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D (Enter nature of injury in Part I ar Part II af item 18.)
MEDICAL	20c, TIME OF INJURY Month, Day, Year Haur e. m	ACE OF INJURY IHome, farm, 20f (City or Iawn) (County) (State) clary, street, office bldg , etc.)
	21. I certify that I attended the deceased from Arry, 1 'r	19 / to 11) 1 / that I last saw the deceased
	alive on 782 12 , 1939 and that death	occurred at 2, 4/4M, from the couses and on the date stated above.
	ACTUAL SIGNATURE M.C. Portci full	M.D. Stores (Street, city or town, stote)  ADDRESS (Street, city or town, stote)  DATE SIGNED  1-12-1
	PHYSICIAN'S M.C.Porterfield	Hampstead M 1/12/59
220	BURIAL, CREMATION, 126 DATE THEREOF 220 NAME OF CEMETERY OF CHAPTERY OF THE CONTROL OF CEMETERY OF CHAPTERY OF CEMETERY OF CHAPTERY OF CEMETERY OF CEM	R CREMATORY 22d LOCATION (City town or county)  LEA SULL OUT DO MI
23/	FUNERAL DIRECTOR'S SIGNATURE Hampateod	240 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE DATE AN 1 5 250

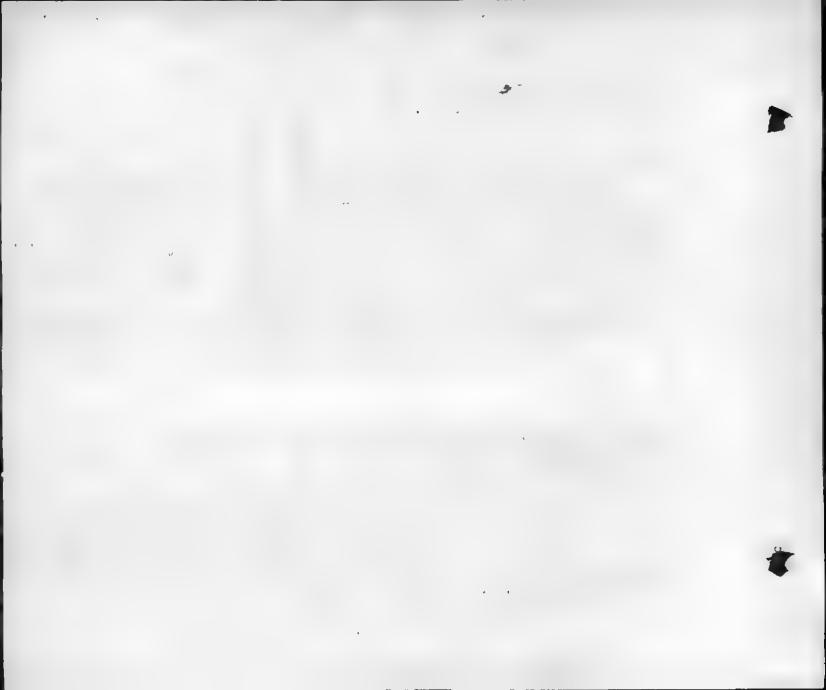


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death.

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY **b.** COUNTY Maryland Carroll MARYLAND Balto City CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporale limits, write RURAL and give nearest town) RURAL and give nearest lown) Baltimore Sykesville davs d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d STREET ADDRESS e. IS RESIDENCE 3531 Falls Road Springfield State Hospital YES NO TO .⊆ NAME OF 4. DATE Middle Month DECEASED OF DEATH 59 McClane Silas Gorsuch January (Type or print) 19 9. AGE (In years lost birthdoy) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS Months December 4, 1874 Male WIDOWED T DIVORCED | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Wagon & Truck Body Builder U.S.A. Maryland codros 14. MOTHER'S MAIDEN NAME William Gorsuch Mary -IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO 17. INFORMANT Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH DAYS: 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate DUE TO couse (b), stoting the underlying couse last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 179. WAS AUTOPSY PERFORMED? Cachexia. YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Port ti of item 18.) certifica MEDICAL 20c. TIME OF INJURY Month. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (Stote) Not while foctory, street, office bldg., etc.) o. m. of work of work 21. I certify that I attended the deceased from January 8 ., 19 59, to January 11, 19 59, that I last saw the deceased , and that death accurred at 8:24P M, from the causes and an the date stated above TOR DATE SIGNED ACTUAL SIGNATURE Springfield State Hospital TO FUNERAL C PHYSICIAN'S Edmund Lusthaus. M.D. Sykesville, Maryland NAME (Type) 220 BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. ŁOCATION (City, town, or county) (Slote) REMOVAL (Specify) Mary's (Hampden) Burri a 1 Baltimore, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR Burgee Funeral Home Fall





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



1. PLACE OF DEATH

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o. COUNTY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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**CERTIFICATE OF DEATH** 474

MARYLAND

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Reg. Dist. No.

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2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)

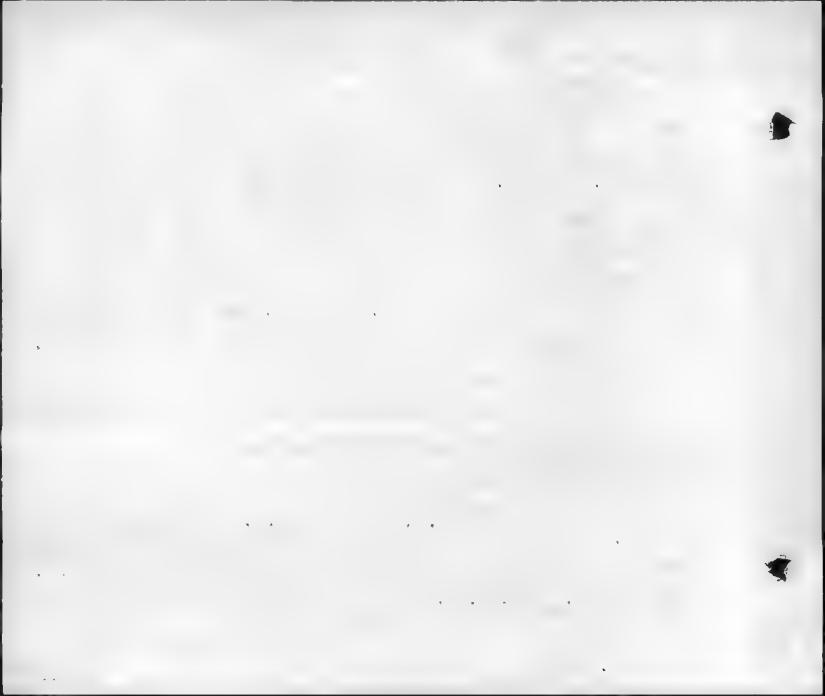
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	this certificate has been signed by the aftending physician and campierely filled in by	or use as the burial-transit permit. Then please remave carbon pepels. Pages I and 2 show	cremation, or removal, and in any event within 72 hours after death
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL DE page 3 shauld bed the registrar prior is VS A15 (4) 15M 10/57

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	b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
1	Eldersburg	X Louisville Koad								
ı	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	1) [								
ı	Louisville Road	Louisville Road	YES NO							
i	3. NAME OF First Middle	Last 4. DATE Month	Day , Year							
ı	(Type or print) //rs. Anna /11. Han	eschlager DEATH January	23rd 19 59							
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ı		Jan 13.1888   71 m	oys Flours Min,							
ł	160 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR IND during, most of working life, even if relired)		EN OF WHAT COUNTRY							
ı	Housewite		USA							
		14 MOTHER'S MAIDEN NAME								
1	Bernard Fortman									
Ì	(If yet, no. or unknown;   (If yet, give wor or datet of service)									
	M	r. (harles f. Haneschlager,	same							
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]		INTERVAL BETWEEN							
	PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (6) GENERAL CARCIN	OMATOSIS								
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	Conditions, if ony, which ) the CARCINONA OF OESOPHAGUS									
	gave rise to immediate (									
		ARDIOVASCULAR DISEASE	10 yrs							
0	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BL	IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART								
ı	GENERAL ARTERIOSCLEROSIS: CHRONI	C MYOCARDITIS	YES NO IX							
ı	20a. ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCURR	ED (Enter nature of injury in Port t or Port II of item 18)								
1	20c. TIME OF INJURY Month, Doy, Year 20d, INJURY OCCURRED 20e.	LACE OF INJURY (Home, form, 20f (City or town) [Co	ounty) (State)							
1	Hour o. m.  While Not while of work of work	belory, street, office blog., etc.)								
RURAL and give pageral town)  A NAME OF HOSPITAL (II not in hospital, give street oddress)  S. SEX  OCINITIZITION  Anna  Middle  Louisville Road  Louisville Road  Louisville Road  A DATE  ON A FARM' YES   NO    S. SEX  OCIOR OR RACE  The page of print)  S. SEX  OCIOR OR RACE  WIDOWED   DIVORCED   S DATE OF BIRTH  JANUARY 237d 19 59  S. SEX  OCIOR OR RACE  WIDOWED   DIVORCED   S DATE OF BIRTH  JANUARY 237d 19 59  Minn.  JOS SISLAL OCCUPATION (Give kind of work done) 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country)  HOUSEWISE  BETTARES NAME  Conditions, if ony, which gave rise to immediate course (p.) toling in the page of the page										
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1	direction of the deal									
ł	ACTUAL CITY OF .									
	SIGNATURE	m.b	the second of the second							
1	NAME (Type) Vm. H. Lawson, Jr., M.D.	Sykesville P.O., Marylan	d							
ı	220. BURIAL, CREMATION, 226 DATE THEREOF 220 NAME OF CEMETERY									
1			land							
			NATURE							
	Leonard J. Ruck 5305 Hartord Roa	d #14 DATE 100 28 59 C	L. JAA							
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24a. REC'D BY REGISTRAR

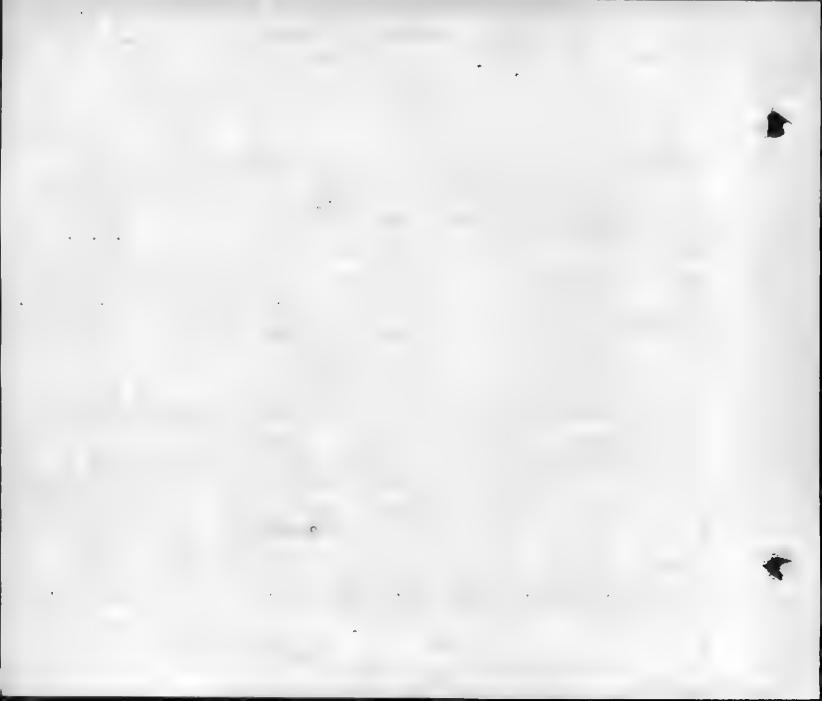
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24b. REGISTRAR'S SIGNATURE

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VS A1S (4) ISM 9/55 23. FUNERAL DIRECTOR'S SIGNATURE

deoth.





## FOR STATE IMALTH DEPT

Page Heolth, 'ar. or files.

The DEPTITY MET. ALL EXAMINER: This certificate should be exemited within 21 himm after section. If any delay is research to execute the color, writing the word "pending" in pendil in Item, 18. Give Pages 1, 2, and 3 to the funeral 4 should be well and the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained 10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State 8 or its designated agent, prior to burial, cremation, or remaral, and in any event within 72 hours after death.

VS A15ME 5M 2'57

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1.	PLACE OF DEATH				2. USUAL RESID	ENCE (Where dece	ased lived. If in	stilution - Residenc	ce before odn	iision)
	o. COUNTY	1	м	ARYLAND	d. STATE	_	b. COI			
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	oug dise seater; jame)	euts de corporale limits, write (f.)	c. LENGTH OF ST	AT IN ID	c. CHT OR IC	WN (If outside co	arporele limits, w	rtite KUKAL ond g	ive nearest to	own)
	Rural	Westminster	12 vrs	.	X Ru	ral Wes	stminste	m		
			nat in hospital, give street ad		d. STREET ADI			-		RESIDEN E
					4					A FAPM?
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3.	NAME OF DECEASED	Firs)	Middle	Hi	lterbri	dla 4 DATE	M	onth	Doy	Yeor
	(Type or print)	HAPLES	THEODI	A RI- IF	FLITIBA	DI DEATH	Ja	2 1	7 1	19-5 4
5.	SEX	6. COLOR OR RACE 7	MARRIED NEVER MAR	177	DATE OF BIRTH	4774	9 AGE in year	a confe	ÆRT IF UND	DER 24 HRS
	m		46 Nr.				Fast birthday)		ys Hours	Min.
	Male	TINT OB	VIDOWED DIVORC			385		res		
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	Laborer	g me, even in remedi	Form		Manual	n d		II C	a	
1 22	FATHER'S NAME		Farm	1	Mary I			U.S	+dh+	
Я.,	. TATTIER 3 HAME				14. MOTHER 3 MI	AIRSEN INVINC				
4	David D	. Hilterbrid	lle		Line	da Stove	er			
		R IN U. S. ARMED FORC		NO. 17. INF	ORMANT		Add	ress		
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			per line for (a), (b), and (c)	1 _					ONSET AND DE	A H
		H WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONAR	VO	LCLLLS	1017			Sec.	
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	Candilians, if or gave rise to immed	ly, which [b]_								
	(a), stating the u									
	cause last.	(c)								
7	PART II. OTH		TIONS CONTRIBUTING TO D	EATH BUT NO	T RELATED TO TH	E TERMINAL DISEA	SE CONDITION	GIVEN IN PART I	Ini 19 WAS	AUTOPSY
CERTIFICATION									FEMILE	ORMED?
2									YES 🔲	NOTX
분	200. EXTERNAL CAU PRIMARY O or CON CAUSE OF DEATH.	ISE WAS 20b	DESCRIBE HOW INJURY OC	CURRED (Ent	ler noture of injur	y in Part I or Fert	11 of item 18.)			/
1 23	CAUSE OF DEATH.	alkianilida (T								
	20c. TIME OF INJUR	Y Month, Day, Year	20d. INJURY OCCURRED	20e PLACE	OF INJURY (Hor	no form 1205 (C	ity or town)	(Caunt	in the same	(State)
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3 H	p. m.	19	ol work of work	3						
	21. I certify th	at I took charge o	if the remains descri	bed abav	e, held an A	utapsy .	Inspection ]	Inquiry	<b>⊠</b> . gr	nd in my
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	SIGNATURE -	111800	March		M.D. CHIEF MED	ICAL EXAMINER			PAIL	SIGNED
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	EXAMINER'S	1	7 11,000	1				/	110	[my]
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23	FUNERAL DIRECTOR	mindle of the state of the stat	Lutherar	- osmer		o. REC'D BY REG!		Maryland EGISTRAR'S SIGN	ATURE	
	merun	n C. russ	]							
	CaC. Fuss	& Son_ I	anextorn. Mar	gland.	0	ATEJAN ? O	29	" Jung B. 9	Tralle.	



22c NAME OF CEMETERY OR CREMATORY

24o. REC'D BY REGISTRAR

DATE AN

**ADDRESS** 

JOHN J. DUDA 7922 Wise Ave. 22. Md.

Reg. Dist. No. Balto. e. IS RESIDENCE ON A FARM? YES NO F Month 19 59 January 2. 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS Months Days Hours 12. CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH Weeks YES NO I (County) (Stote) DATE SIGNED 2/59 22d. LOCATION (City, lown, or county) 1959 Sacred Heart of Jesus German Hill Rd. Md. 24b REGISTRAR'S SIGNATURE

0 VS A15 (4) NAME (Type)

270 BUR AL, CREMATION, 226 DATE THEREOF

23. FUNERAL DIRECTOR'S SIGNATURE



3		MARYLAND STATE DEPARTMENT OF HEALTH-BAL	TIMORE, 18 $00470$
FOR STATE		MEDICAL EXAMINER'S CERTIFICATE OF	DEATH Reg. Dist. No.
HEALTH DEPT.		LACE OF DEATH	ed lived. If institution: Residence before admission)
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d	į į	CITY OR TOWN (1 outside corporate limits write EJRAL C LENGTH OF STAY IN 16 C CITY OR TOWN (If outside corporate limits write EJRAL C LENGTH OF STAY IN 16 C CITY OR TOWN (If outside corp	orate imits, write RURAL and give nearest town)
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10 m		18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c) ]	NTERVAL BETWEEN ONSET AND DEATH
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MIN niting prior	2		spection [X] Inquiry [X], and in my
ded to gent.		opinion death resulted from. Notural couses 🗖 Accident 🔲, Suicide 🔲, Hamicide	, man , , , , , , , , , , , , , , , , , , ,
IR CO		ACTUAL SIGNATURE SULLS I MANUAL M.D. CHIEF MEDICAL EXAMINER []	DATE SIGNED
Y Me		EXAMINER'S JANA E.S. T. MIRS H DEPUTY MEDICAL EXAMINER TO	1/12/5-9
t de la contra del la contra de la contra del la contra del la contra del la contra de la contra del	220		IQN (City, town, or county) (State)
0 9 4 0 9		Bury 1/15/59 West nothingham Co	lone Cecil Co, ma
YS A15ME	23.	UNERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTR	AR 24b. REGISTRAR'S SIGNATURE
5M 2/57	4	halfn m Greed Greing sun, ma DATE AN 1 4 '50	anthur & Frances



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	may be retained the haspital at attending physician.  TO FUNERAL DIR. FOR: After this certificate has been signed by the attending physician and campletely filled in by the proof director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filter with	the registrar prior to burial, cremation, ar remaval, and in any event within 72 hours after death		
TAL	RAL show	istrar		
HOSE	FUNE	e regi		
10	E D a	H.		

VS A15 (4) 15M 10/57

	41						Reg. Dist	. No.		
1 PLACE OF DEATH			2	USUAL RESIDENCE (M	here deceas		on. Residence	before adm	iss on]	
o. COUNTY Carroll		MARYLAN	D	o STATE Marv	land	b. COUNTY				
b. CITY OR TOWN (If outside corporate	limits, write	c. LENGTH OF STAY IN 1	ь	c. CITY OR TOWN (If		porote limits, write R	URAL and go	give nearest town)		
RURAL and give negrest town) (Rural) Sykesv	ille	7yr.9mo.9da	V3	Balti	more	Gi tav	* 'V'	v' ' ' . L'.		
d NAME OF HOSPITAL (IE not in haspi									ESIDENCE A FARM?	
Springfield Sta	te Host	oital		1115 E.	Balt:	imore Str	cet		NO D	
3. NAME OF	First	Middle		Losi	4. DATE OF			Day	Year	
(Type or print) Loui	sa	Wilhelmin	a	KREIT	OF DEAT	H Januar	7	22	1959	
5. SEX 6. COLOR OR R	ACE 7. MAR	RIED NEVER MARRIED	9. D	ATE OF BIRTH		9. AGE (In years		YEAR IF UN		
Female White	WIDOW	ED T DIVORCED		9-11-1862		last birthday) 96 yrs	Months D	Days Haur	s Min	
100 USUAL OCCUPATION (Give kind of viduring most of working life, even if re	ork done 10b.	. KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (Stote	e ar foreign		12. CITIZ	EN OF WH	AT COUNTRY	
None	rired)			Maryland			U	.S.A.		
13. FATHER'S NAME			1	MOTHER'S MAIDEN	NAME					
John Schuh				Wilhelm	ina B	ock				
15. WAS DECEASED EVER IN U. S. ARMED	FORCES? 16.	SOCIAL SECURITY NO. 17	7 INFO			Addi	ress	······································		
No	as or service)	None	Hos	pital reco	rds					
18 CAUSE OF DEATH [Enter only o	ne cause per li	ine for (a), (b), and (c).]			<del></del>			INTERVAL	BETWEEN	
PART I. DEATH WAS CAUSED IMMEDIATE CAU	BY, SE (o) F	Pulmonary emb	olis	711				1 da		
11/1/ \	€ TO			,					~	
Conditions, if any, which )	(b) R	Rheumatic hea	rt d	isease						
gave rise to immediate DL cause (a), stating the under-	£ TO								*	
lying cause last.	{c}									
PART II OTHER SIGNIFICANT	CONDITIONS	CONTRIBUTING TO DEATH	OUT NO	RELATED TO THE TERA	AINAL DISEA	SE CONDITION GIV	EN IN PART	DED	ENDIMENT	
Chronic brain sylor or nutrition, wi	larome Lh seni	associated w	itn ease	disturbanc with psy	e of r	netabolism	a gro	Wth YES	NO [	
Part II OTHER SIGNIFICANT Chronic brain syn or nutrition, wi 20% ACCIDENT WAS UNDERLYING E OR CONTRIBUTING II CAUSE OF DE IIF EITHER, NOTHEY MEDICAL EXAMIN	20b. DES	CRIBE HOW INJURY OCCU	RRED (E	nter nature of injury in	Part Lar Pa	ort II of item 18.)				
	IER)									
20c. TIME OF INJURY Month, Day, Hour a.m.			PLACE	OF INJURY (Home, for street, affice bldg., et	m, 20f (Ci	ly or lawn)	(Co	ounty)	(Store)	
p. m.	19 White		,	, meer, arried grogs, ar						
21. I certify that I attended	the deceas	sed from		. 19:55 to	1-22	, 1959	that I lo	ast saw th	e decease	
alive on 1-21			ath oc	curred at 8:00	A.M. fro	om the causes of	and on the	e date sta	ited above	
11-1	+	1%				Street, city or town,			DATE SIGNE	
SIGNATURE SIGNATURE	3	lus nu	M.D	Springfi	eld St	tate Hospi	ital	1	-22-59	
		10								
PHYSICIAN'S Walte:	Knopp	, M. D. (		Sykesvil	le, Ma	aryland	********			
220. BURIAL, CREMATION, 226 DATE TH	EREOF	22c. NAME OF CEMETER	Y OR CR	EMATORY	22d. LOC.	ATION (City, town, o	or county)	(51	tate)	
Burial Jan. 2	4.195	9 Trinity	Cen	netery	I	Baltimor	e. Ma	rylar	nd	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC	'D BY REGI	STRAR 246 REGIS	STRAR'S SIGN	NATURE		
H. SANDER & SONS	, INC.	Balto.,	Md.	DATE J	AN 26	'59 L.	com &	AHA		



may be retained by the hospital ar attending physician.

TO FUNERAL LACE TOR: After this certificate has been signed by the attending physician and campletely filled in by thereof director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or remaval, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death. Page 4 VS A15 (4) 15M 9/55

		4	80	CE	RTIFIC	ATE	OF D	EATH	1			Reg. Di	st. No.		
1.	PLACE OF DEATH O. COUNTY Carroll				MARYLAND		. STATE	ence (wh	ere decesses		OUNTY	n Residen			ion)
	b. CITY OR TOWN (If RURAL and give nea	outside corporate limi	ts, write	c LENGTH OF	STAY IN 16	c			utside corpo	rote limits					n)
	Sykesy111e		un alenni	6 m 8	days		Hage:	rstow	n		21	103		e. 15 RES	IDENCE
	Springfiel								veland	Ave	mue			ON A	NO K
	NAME OF DECEASED (Type or print)	Fir	••		Middle Ina	I	lost AWY9n		4. DATE OF DEATH		Month	1	Do 3	*	Yeor 19 59
5		6. COLOR OR RACE			WARRIED [		TE OF BIRTH			9. AGE { lost bi	in years ribday)	Months	Doys	IF UND	ER 24 HRS
100	Fem. USUAL OCCUPATION	White N (Give kind of work	done 10b.	<b>A</b>		1 01			or foreign co		,,,,,,	12. CI	TIZEN O	F WHAT	COUNTRY
	during most of working Housewife	ng`life, even if retired		1/2	mi	1	Pan	nsylv	ania			Ţ	J.S.	A .	
13.	FATHER'S NAME			and the second		14	MOTHER'S			4					
	Alfre	d Churchil	1				6	Into	nece	76/					
	WAS DECEASEDEVER	IN U. S. ARMED FOR tyes, give wor or dotes of s		SOCIAL SECURIT	y NO 17	INFOR	mant ngf.Ho	spita	1 Reco	orda	Addre	258			
	PART I. DEAT	H [Enter only one co		onchoon		a							ONS	RVAL BI	ETWEEN DEATH
	4-91X	IMMEDIATE CAUSE (o DUE TO		<u>rollensofone</u>	e En disfaha en di	- L					-				
	Conditions, if on gove rise to im couse (o), stating the lying couse lost.	mediate (		···											
ATION		RAIGNIFICANT CON		STRUCTUS	Fory d	1884	IT DEME	STEEL STEEL	Mr 6846	Barg1	OHEN	omina	ache	PERFO	AUTOPSY DRMED?
CERTIFICATION	200. ACCIDENT WAS OR CONTRIBUTING OF	L. reaction S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b DES	CRIBE HOW INJ	URY OCCURR	ED. (En	ler noture of	f injury in I	Part I or Part	t II of iten	18)			163	NOE
MEDICAL	20c. TIME OF INJURY Hour a.m. p. m	Month, Doy, Ye	or 20d II While of wor	NJURY OCCURRE Not while It of work	(D 20e. P	LACE C	F INJURY (I street, office	Home, form bldg, etc	20f. (Cily	or lown)		(	County)		(Stote)
	21. 1 certify the	at I attended the	deceas		7-23- that deat		, 195 urred at	140 I	1-31 M, fron	n the co	ouses or	nd on t		te stat	
	ACTUAL SIGNATURE	lucums	J.	usth.	Pu	M.D.	Sprin		address (Si d Sta					_	ATE SIGNE L-31-5
	PHYSICIAN'S NAME (Type) Fig	imund Inst	ha us	M.D.		_	Syke	svil	le, Ma	rylaı	nd.				
	BURIAL, CREMATION REMOVAL (Specify)	2-4-	.59	22c. NAME O	F CEMETERY (	OR CRE	MATORY		22d. LOCAT	like	into	4	70	) (Sto	le)
23	FUNERAL DIRECTOR'S	SIGNATURE	Shit	ADDRESS	hante	1/21	Gref.	24a. REC'	B 4 15		46 REGTS	TRAR'S SI			



DATE

e. IS RES DENCE

YES TO NO P

INTERVAL BETWEEN ONSET AND DEATH

hrs.

PERFORMED? YES NO T

months

(Stole)

DATE SIGNED

(Stote)

Md.

6

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15M 10/S7



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VS A15 (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

	MARYLA	ND STATE DEPARTM	ENT OF HEALTH	I—BALTIMORE, 18	00474
	422	CERTIFICA	ATE OF DEATH	ı,	Reg. Dist. No.
	1. PLACE OF DEATH COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (Who o. STATE Maryla	nd b COUNTY	Residence before odmission) Carroll
	b. CITY OR TOWN (If outside corporate limits, wi RURAL and give nearest town)			utside corporate limits, write RUR	(AL and give nearest town)
	(Rural) Sykesville  d NAME OF HOSPITAL (If not in hospital, give st OR INSTITUTION	3years 1 day	d. STREET ADDRESS		e. IS RESIDENCE
	Springfield State H	ospital	Westmins	ster Road	ON A FARM? YES NOY
	3. NAME OF First DECEASED (Type or print) ROSell		LEIGHT	4. DATE Month OF DEATH Januar	Doy Yeor CY 20 1959
		WARRIED NEVER MARRIED DIVORCED DIVORCED	8 DATE OF BIRTH 10-20-84	(gst b rindoy)	FUNDER TYEAR IF UNDER 24 HRS Wonths Days Hours Min.
	Female White WID  100 USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)			or foreign country)	12 CITIZEN OF WHAT COUNTRY
	Housewife		Maryland		U.S.A.
2000	13 FATHER'S NAME Alfred Keeney		Margaret B		
0	15. WAS DECEASED EVER IN U. S ARMED FORCES?  (Yes, no or unknown)   (If yes, give war or dates of service)		NFORMANT	Address	•
	NO	<u> </u>	Mospital Recor	ds	
	18. CAUSE OF DEATH (Enter only one couse p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)	ivocardial Infarc	tion:		INTERVAL BETWEEN ONSET AND DEATH Hours
		rteriosclerotic eneralized Arter			Years Years
	Conditions, if ony, which gave rise to immediate couse (a), stating the <u>under-lying couse</u> lost.	reneralized Arbei	TOSCIETOSIS		1ears
		ens contributing to DEATH BUT associated with	NOT RELATED TO THE TERMIN	of metabolism,	growth yes No M
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in P	art I or Port II af item 18 }	
	Haur a.m.	Od, INJURY OCCURRED  Thile Not while for work at work	ACE OF INJURY (Home, farm, ctory, street, office bldg., etc.	20f. (City or town)	(County) (State)
	21. I certify that I attended the dec	eased from 1-19	, 19 <u>56</u> , to 1-	20 1956	that I last saw the decease
	6, , 0	-		M, from the causes and	d an the date stated above
	SIGNATURE LA MILLIA SI	colhan	MD. Springfie	ld State Hospit	tal 1-21-59
	PHYSICIAN'S Edmund Lusth	naus, M. D.	Sykesvill	e, Maryland	
	220 BURIAL, CREMATION, 226. DATE THEREOF REMOVAL (Specify) Jan. 24, 19	22c. NAME OF CEMETERY O Finksburg	R CREMATORY	Finksburg A	
	23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		8Y REGISTRAR 246. REGISTR	RAR'S SIGNATURE
	J.F.Eline & Sons,R	eisterstown, Mo	DATE TO	V 2 2 '59 C.	" 1 & KinyA

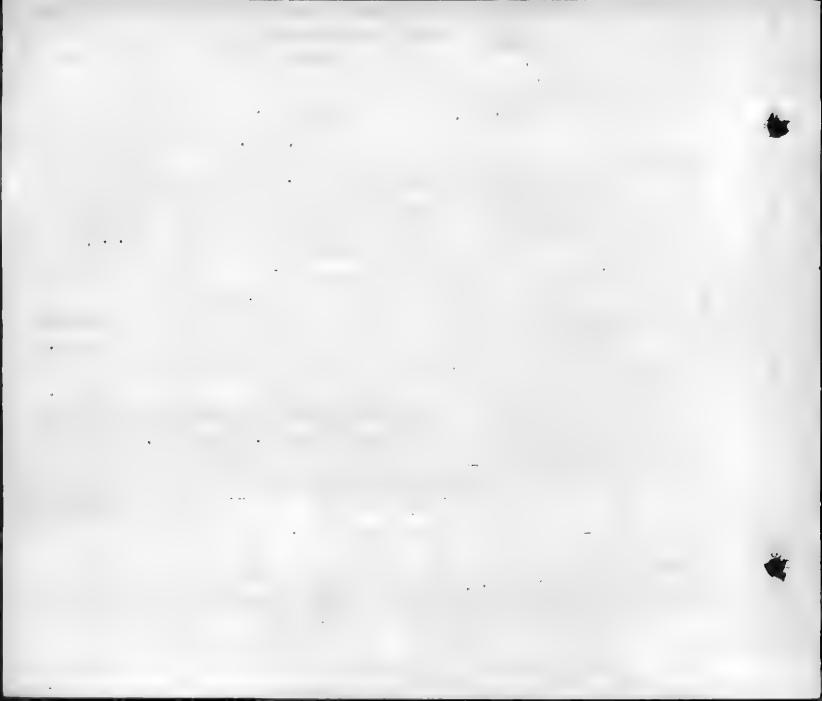


may be retained by the haspital ar attending physician.

D FUNERAL IN TIOR: After this certificate has been signed by the attending physician and completely filled in by Juneral director, page 3 shauld as detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL A VS A1S (4) 15M 9/55

		833	CERTIFIC	574 II	E OF BEAT	П			Reg. D	ist. No.		
1. PLACE OF DEATH  o. COUNTY  Carroll			MARYLAN	D	USUAL RESIDENCE (Vo. STATE Maryland		ceased	lived. If institution b. COUNTY	oni Reside	nce befo	re odmis	sion)
RURAL and give r			LENGTH OF STAY IN THE	Ь	CITY OR TOWN (II	foutside	corporo	ita limits, writa R	URAL ond	give nec	rest fow	n) ~
(Rural)	Sykesville,	Md.	Imo Edam		Baltimor	re ,	11				1	
OR INSTITUTION	TAL (If not in hospilo), p				3 STREET ADDRESS	37t1	n. S	treet				FARM?
3. NAME OF	Fil		Middle		Lost	4. D	ATE	Men	th	Da		Yeor
(Type or print)	Cha	rles	Edgar		Lohr. Sr.	0	F EATH	1		7.5		1959
S. SEX			IED X NEVER MARRIED	) e. D.	ATE OF BIRTH	l	9	AGE (In years lost birthday)	IF UNDE	RIYEAR		ER 24 HRS.
Male	White	WIDOWE		-	3-1-82			76 yrs.	Manthu	Doys	Hours	■ю
100 USLAL OCCUPATI	ON (Give kind of work rking life, even if retired	done 10b	KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (Stol	le or for	eign cou		12. Ci	TIZEN C	F WHAT	COUNTRY
Steam fire					Marrel	land			U	.S.		
13. FATHER'S NAME				14	. MOTHER'S MATDEN							
John	L. Lohr				Agnes	5-						
15 WAS DECEASED EV	ER IN U. S ARMED FOR		SOCIAL SECURITY NO 17	INFO	RMANT			Adde	· 115			
unknown			unknown	Re	cords Spri	ingf	ield	State I	Hos pi	tal		
										- 2	RVAL BE	DEATH
Conditions, if a gove rise to couse (o), stating lying cause lost.	the under-		rteriosclero	tic_	cardiovasc	ulaı	di:	86320			ore O yr	than s.
200 ACCIDENT WORK CONTRIBUTING			ONTRIBUTING TO PEATH IS THE RESERVE OF T							R 1(o)	9, WAS PERFO YES	AUTOPSY PRMED? NO K
ZOC, TIME OF INJU Hour a.m.	RY Month, Day, Ye	20d IN While of work	Not while		OF INJURY (Home, for street, office bldg , e		(City o	or town)	(	(County)		(State)
actual signature PHYSICIAN'S NAME (Type)	Walter Kno	pp, 1	4 -	M.D	, 19,55, to_curred at ]]:]				nd an i		le state	deceased ed above ATE SIGNED
BUTION SPECIFY	1/10/	59	WESLEY	4.	PEL	22d	PAPA	ON (City, town, o	2, 1	1D.	(Sto)	e)
auctin/	E Konov	an/-	3818 Roun	HD	AVE DANA	C'D BY R			TRAR'S SI			



VS AfS (4) 15M 9/SS

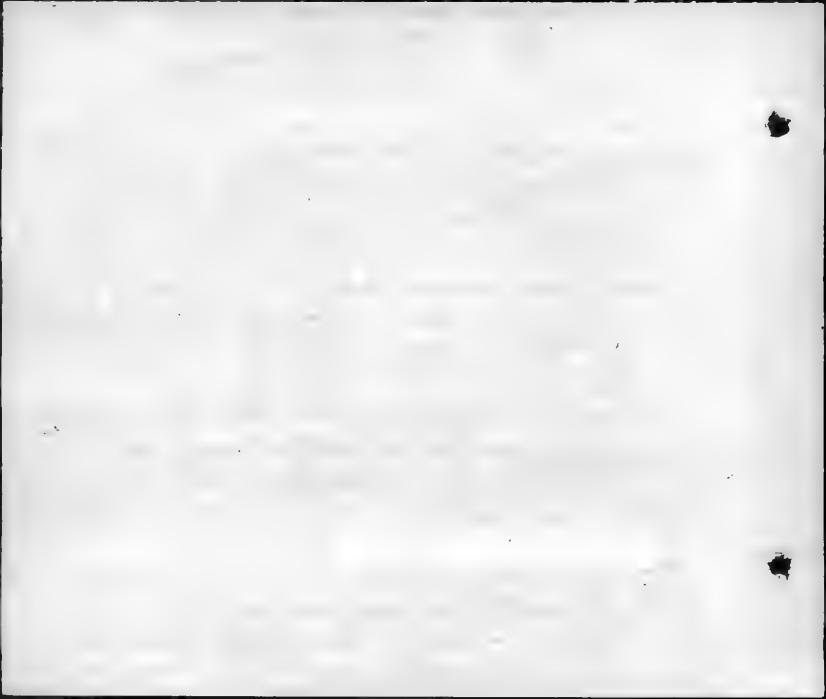
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

484 CERTIFICATE OF DEATH

00478

Reg. Dist. No.

	b. CITY OR TOWN (If outside corporate limits, write RURAL and give regarest lows)	o. STATE 7rid b. COUNTY	
1 1	( KUKAL ond give negrest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give	nearest town)
1	Mrightoter	Balto. 24 . +	,
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	15 RESIDENCE ON A FARM?
3	NAME OF First Middle	Lost 4. DATE Month	YES NO
	OFCEASED (Type or print) Alanny much	est DEATH Jan d	Doy Year 19 59
52	SEX   6. COLOR OR RACE   MARRIED   NEVER MARRIED   DIVORCED	8 DATE OF BIRTH 9 AGE (in years lif UNDER 1 Y lost birthday) Months Da	EAR IF UNDER 24 HRS  195 Hours Min
100	USUAL OCCUPATION (Give kind of work done fob. KIND OF BUSINESS OR INDU		N OF WHAT COUNTRY?
7	resonnal (ret.)	md. C	1.5.a.
13	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
		INFORMANT Address	
lYo	72. no, or unknown)	1. Raymond Prinche	it
	f8. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Lahar 1	neumono	10 days
	DUE TO	The Tai Heart Dies	5-600
	Conditions, if ony, which gove rise to immediate DUE TO	1 de la companya del companya de la companya del companya de la co	
	lying couse lost.  (c) Glubralize	1 autemordens	5 yes -
TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	o) f9. WAS AUTOPSY PERFORMED?
CERTIFICATION	20g. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in Port 1 or Port II of item f8.)	YES NO
	OR CONTRIBUTING CAUSE OF DEATH	D. (Enter notice or injury in Port 1 or Port 11 of Hem 16.)	
MEDICAL	Hour o.m. While Net while ! fo	ACE OF INJURY (Home, form, 20f. (City or town) (Courtry, street, office bldg., etc.)	nty) (State)
PA6	p. m. f9 of work of work		
	21. I certify that I attended the deceased from 12-20	, 1954, ta 1-24, 1959, that I las	t saw the deceased
	dive different section (1997), and that death	a occurred at 10:30 P.M., from the causes and an the ADDRESS (Street, city or town, state)	date stated above.  DATE SIGNED
	SIGNATURE W/ Hoard	M.D. Manchester Md.	1-24-59
	PHYSICIAN'S W. H FOARD. M.D	· Marchester, M	4
220	BUR AL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY CORRESPONDENCE OF COLOR	R CREMATORY 22d. LOCATION (City, town, or county)	(Stote)
25.	FUSIERAL DIRECTOR'S SIGNATURE  ADDRESS 78	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNA DATEJAN 2 7 '59 Corbus & H	

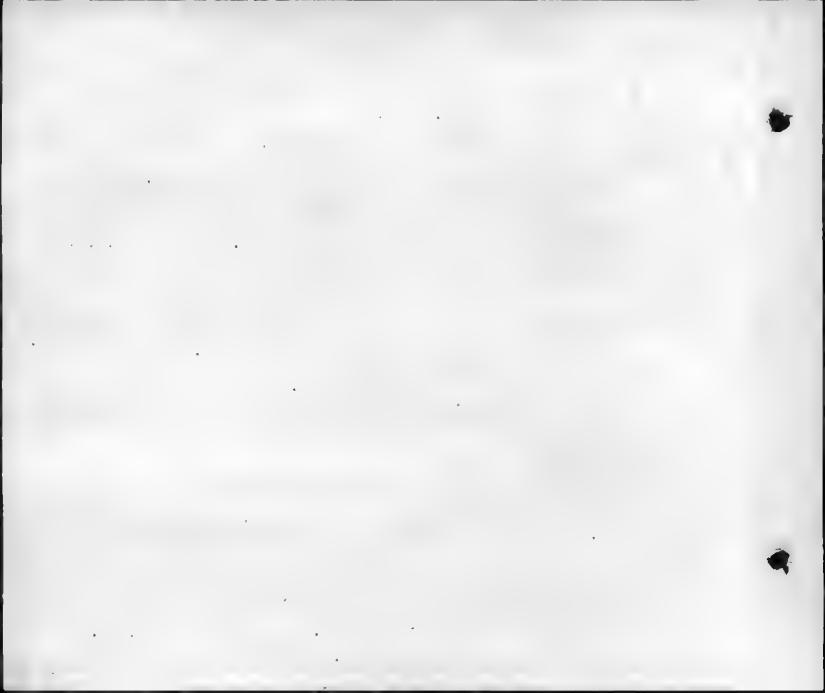


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death		Mendir	please	within
hat the		y the c	Then	event
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SICIAN	ottendi	ertifical	as the	an, ar
3 PHY	ntal ar	r this co	or use	cremati
NIGN	ne hasp	R: After	ached f	ourial,
R ATT	÷ /2	ĮŌ.	S det	or to
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4	may be retained by the haspital or attending physician.	TO FUNERAL D. FOR: After this certificate has been signed by the attending physician and completely filled in by Luneral director,	page 3 shauld to detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with	the registrar prior to buriat, cremation, ar remaval, and in any event within 72 hours after death.
HOSP	dy be	FUNER	oge 3 s	e regis
10	E	9	ā.	£

VS A15 (4) 15M 9/55

N	200	CERTIFICA	IE OF DEATH	Reg. Dist. N	0.
	1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased o. STATE Maryland	lived. If institution: Residence be b. COUNTY Balto	
,	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Sykesville	c. LENGTH OF STAY IN 16  2yrs.10mos.13	c. CITY OR TOWN (If outside corpore lays Baltimore	te limits, write RURAL and give n	earest town)
>	d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION Springfield State Hospit		d street address 1531 N. Mi	lton Ave.	e. IS RESIDENCE ON A FARM? YES NO 20
	3. NAME OF DECEASED (Type or print) Ella V	irginia l	Madigan 4 DATE OF DEATH	Januar	8, Yeor 59
	5. SEX 6. COLOR OR RACE 7. MARR Female White WIDOWI		Dec. 11,1871	AGE (In years IF UNDER LYEA lost buthday) Months Days	Hours Min.
	10a USUAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired) HOUSEWITE	KIND OF BUSINESS OR INDUST	Balto. Md.		S.4.
	3. FATHER'S NAME Edward Egan		14 MOTHER'S MAIDEN NAME	Lyons	-
	15. WAS DECEASEDEVER IN U. S. ARMED PORCES? (Yer, no or unfantum) (If yes, give wor or datas of service) (If yes, give wor or datas of service)		formant Springfield Hospita	Address 1 Records	
	18 CAUSE OF DEATH (Enter only one couse per fire PART I DEATH WAS CAUSED BY: CE	ne for (0). (b). ord (c) ] rebral arterios	sclerosis	IN O	TERVAL BETWEEN USET AND DEATH LOSI'S
	Conditions, if ony, which (b)				
	gove rise to immediate cause (a), stating the <u>under</u> lying couse lost,				
	C.B.S. ASSOC. With core with Pulmonary tuberculosis.	X.8			19. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURRED.	. (Enter noture of injury in Part I or Part I	l of item 18)	
l	Hour o. m. 19 While of world	k ot work	CE OF INJURY JHome, farm, 20f. (City of ory, street, office bldg., etc.)		
ı	21. I certify that I attended the decease alive an January 6, 795	ed from February	23, 1956 , to January occurred at 10:05PM, from	6, 1959 that last the causes and an the d	saw the decease
	ACTUAL SIGNATURE Educad Lu	sthans "	ADDRESS (Sire Springfield Sta	et, city or town, state) te Hospital	1/7/59
	PHYSICIAN'S Edmund Lusthaus	s, M.D.	Sykesville, Mar	yland	~~~~~~~~~
	220. BURIAL, CREMATION, 22b. DATE THEREOF 1-10-59	Baltimore		ON (C by. town, or county)  1to. Md.	(Stote)
	John C Miller Inc. o	ADDRESS 2434 E Oliver	Street DATEAN 1 2 '59	AR 246 REGISTRAR'S SIGNAT	URE





CERTIFICATE OF DEATH

		701	CLK	IIIICAI	L OI DI	-~!!	1		Reg.	Dist. No	4	
	1 PLACE OF DEATH o COUNTY			2	USUAL RESIDE	NCE (WI	here deceased	d lived. If instituti	on Resid	lence befo	re odmis	sion)
	CarrolI		MJ	RYLAND	o STATE			b COUNTY				
/	b CITY OR TOWN (If outside RURAL and give negrest I	de corporate limits, write	c. LENGTH OF ST	AY IN 1b			outside corpoi	rote limits, write R	URAL on	d give ne	arest low	n)
	Sykesville (r	urall	5 mont	hs	Rocky	ille			2 m			
	d. NAME OF HOSPITAL (IF	not in hospital, give stre	of oddress)		d. STREET ADD	the same of the same					e. 15 RES	DENCE
	Springfield	State Hospi	tal		Grea	t Fa	lls Ro	pad			YES [	NO THE
	3 NAME OF DECEASED	First	Mid	dle	Lost		4. DATE OF	Mon	th	Do	у	Yeor
		anvin	Arthur	A	UNGER		DEATH	1		17		159
	5. SEX 6. CI	OLOR OR RACE 7. MA	RRIED   NEVER MA		ATE OF BIRTH	1.9	372	9. AGE (In years		ER I YEAR		ER 24 HRS.
		11444	- Jimi	CEO [1]	2C _ 30	,		80 yrs	Months	17"	Hours	Min
	100. USUAL OCCUPATION (Gi during most of working life	ve kind of work done 10 e, even if retired)	E KIND OF BUSINES	OR INDUSTRY	11. BIRTHPLAC	E (Slote	or foreign co	ountry)	12. 0	ITIZEN C	F WHAT	COUNTRY
	RealeState				Virg	inia	. U.S	6.A.		U.	S.A.	
	13. FATHER'S NAME			1	4. MOTHER'S M	AIDEN N	NAME					-
	John B. Mung				Eliza	Hof	fman					
	15 WAS DECEASED EVER IN U	. S. ARMED FORCES? 1.	6. SOCIAL SECURITY I	17. INFO	RMANT			Add	ress			
	no	La	79-22-6108	A Rec	ord: Sp	ring	field	State Ho	spit	al		
	18. CAUSE OF DEATH [E	inter only one couse per	line for (o), (b), and	(c). ]						INT	ERVAL BE	TWEEN
	PART I DEATH WA	S CAUSED BY DIATE CAUSE (6)	Xlateral I	Bronchop	neumoni	a				da	TYS AND	DEATH
	491x	OUE TO			-							
A. C.	Conditions, if any, wi	nich ) as										
	gove rise to immed	ole (										
	couse (a), staling the <u>un</u> lying couse fast	(c)										
	PART II. OTHER SIC	NIFICANT CONDITIONS	CONTRIBUTING TO	DEATH BUT NO	T RELATED TO TH	IE TERMI	NAL DISEASE	CONDITION GIV	EN IN PA	ART 1(o) 1	9 WAS	AUTOPSY
	PART II. OTHER SIG	o arterioso	lerosis v	rith psy	chotic	read	ction				PERFO	RMED?
		ERLYING [] 20b. DI	SCRIBE HOW INJURY					If of item 18.)			112-6-1	140
	OR CONTRIBUTING CA	USE OF DEATH					T					
	3 20c. TIME OF INJURY MO	nth, Doy, Year 20d.	INJURY OCCURRED	20e. PLACE	OF INJURY (Hor	ne, form	20f. (City	or town)		(County)		(Stole)
	20c. TIME OF INJURY Mo	19 While	e Not while	foctory	, street, office bl	dg., etc.	3			, , ,		(0.012)
			A 2 2 2	just 8	1958	Te	m 18	.50				-
	21. I certify that I delive an Jane 1	7	7.2					, 1922_	that	I last so	iw the	decease
	alive an Jalle I		and th	at death ac	curred at ±			the couses o		the do		
	ACTUAL OF	intra Du	0/1	ha	Sprin	ofie	AUUKESS (SIC	reel, cily or lown. Ate Hospj	[eloit			ATE SIGNE
	SIGNATURE COLUM	win ac	1 Carry	M.D.	Obs mi			acc nospi	LVAL			10-57
ľ.	PHYSICIAN'S Agu	stin del Ca	mpo.M.D.		Sykes	vill	e, Mary	land.				
	220 BUR AL CREMATION, 22		. 22c NAME OF CI	METERY OR CR	EMATORY		22d LOCAT	ION (City, town, e	or county	)	(Sigh	e}
	Burial (Specify)	L-20-59	Monocacy	/ Cemei	tery			lsville			and	
	23. FUNERAL DIRECTOR'S SIGN	ATURE	ADDRESS		24	lo. REC'I	D BY REGISTI	RAR 24b REGIS	STRAR'S	IGNATU	RE	
	Robert A. Pu	mphrey, Bo	ethesda,	Maryl	and o	ATE JA	N 2 0 '5	9 a.	ilut o	. Ftrace	4	

may be retained by the haspital ar attending physician.

TO FUNERAL D: FIOR: After this certificate has been signed by the attending physician and campletely filled in by Juneral director. page 3 should be detached far use as the burial-transit permit. Then please remark carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, at remaval, and in any event within 72 hours ofter death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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VS A15 (4) 15M 9/SS



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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00480

283	CERTIFICATE	OF DEATH	
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	U	17	7.	'/	4
			9	l.	

			2.							110 87 010	** ****	
	COUNTY C	arroll		MARY	LAND	2. U	SUAL RESIDENCE (Who state Mary 1		d lived. If instituti b. COUNTY	oni Residenc	e before o	dmission)
b.	CITY OR TOWN (I	f autside corporate limiterest town	ls, write	c. LENGTH OF STAY	IN 16	С	CITY OR TOWN (If ou	riside corpo	prote limits, write R	URAL and gi	ive nearest	town)
	Henr			1,506 day	ys		Balti	more	2	V	* F	
d.	NAME OF HOSPIT	AL (If not in hospital, g	ive street	oddress)		•	STREET ADDRESS				e. 19	S RESIDENCE
		Henryton S	tate	Hospital			1669	W. No	orth Ave:	nue		S NOJ
DE	LME OF CEASED (pe or print)	Fire Joh	nnie	Middle		1	tosi Vers	4. DATE OF DEATH	Januar		Doy 22	Year 195
5. SEI	(			HED NEVER MARRIE	р∏В		TE OF BIRTH	l	9. AGE (In vents		YEAR IF	UNDER 24 HRS
M	ale	Negro	WIDOWI			An	gust 22. 1	922	lost birthday) 36 yrs.	Months	Doys Ho	ours Min
10a t	SUAL OCCUPATIO	ON (Give kind of work of	ione 10b.	KIND OF BUSINESS OF					1	12 CITI	ZEN OF W	HAT COUNTRY
°	iuring most of worl No	king life, even if retired) 710					South Ca	roli	10		USA	
13. FA	THER'S NAME					14	MOTHER'S MAIDEN NA		i CC		ODF	1
		Isaiah My	ers				Martha	Roh	ingon			
15. W	AS DECEASED EVE	R IN U. S ARMED FOR	CES? 16	SOCIAL SECURITY NO	17. IN	FOR/		1100.	Addi	ress		
	No	(If yes, give wer or dotes of s	-	48-28-6542	2 .10	ohi	nnie Myers	_ P	ationt			
		ATH [Enter only one co				V.84.	MARK EN SELD				INTERVA	AL BETWEEN
	PART I. DEA	TH WAS CAUSED BY:	Far	advanced	hila	e ta	eral pulmo	namu	tuhercui	losis	ONSET 4	Vears
	2 7 12	DUE TO	4 (02		10 44 45, 1		CRUA PUAMO	ALCOL Y	ouber ou	TODID	1/6	3 6 67 5
	Conditions, if o	ny, which )										
	gove rise to i	mmediote ( Dus 70									1	
	couse (a), stating lying cause last.	the <u>under-</u>										
CATION	PART II. OTH	HER SIGNIFICANT CON		ONTRIBUTING TO DEA	TH BUT N	101	RELATED TO THE TERMIN	NAL DISEAS	E CONDITION GIV	EN IN PART	P	VAS AUTOPSY ERFORMED? S NO
0 0	OG ACCIDENT WA OR CONTRIBUTING FEITHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINERS	20b. DES	CRIBE HOW INJURY OF	CCURRED	(Ent	er noture of injury in Pr	ort I ar Par	t II of item 18 )			
MEDICAL	Hour o.m.	Y Month, Day, Yea	While	Not while	20e PLAC	CE O	f INJURY (Home, form, treet, affice bldg., etc.)	20f (City	or town)	(Ce	ounty)	(State)
2	1. I certify th	at I attended the	decease	ed from Decemi	ber 8	8	154 toJan	uary	22 19 5	9 that I id	ast saw	the deceases
	live on Jan						rred at 11:45					
		/ /		*					treet, city or lown,		0 0010 1	DATE SIGNED
	CTUAL C	. M. Max	2760	ces 121,2	7 . M	LD ,	Henry	ton,	Harylan	d		1-22-59
PX	HYSICIAN'S E	. M. Macul	ans,	M. D., St	ipt.		Henryton	Star	te Hospi	tal		
	URIAL, CREMATIO		1-0	22c. NAME-OF GEME	TERY OR	CRE	MATORY	224 ADCA	TION (City, fown, o	or county)	/	(Stote)
	Burial Specify)	1/26/0	) /	wit.	il	N	aris	Na	eleng	ten.	MI	(
23. fl	INERAL DIRECTOR	SIGNATURE		ADDRESS //		1,	24a. REC'D		1 / /	STRAR'S SIG	NATURE	
, De	TUAN	-11-12	× 11	11631hh	ud	pho	- PIZZZ DATEJAN	27 5	9 /	* * * *		

VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

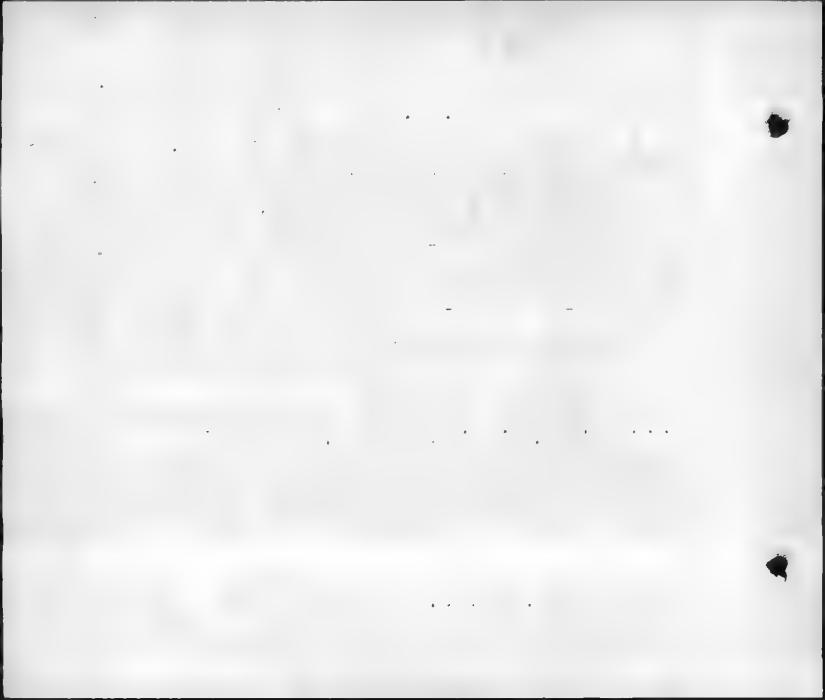
00481

		1.4	3.5						Reg. Dis	t. No.
1. 1	LACE OF DEATH	Manager State of Stat		y warmen is and reference	2 USUAL	RESIDENCE (W	here deceased	I ved. If institu	tion Residen	sce before admission)
	Car	roll		MARYLAN	o. STATE	Marv	lend	b. COUNT	Y Balt	co.City
Ь	CITY OR TOWN IT	ouls de corparule limits, willi	FUPAL .	C LENGTH OF STAY IN T	c. CITY	OR TOWN (II	outside corpor	ole limits, wr'te		give nearest lown)
	Svkesville			lyr.8mos.22d	ays	Baltin	nore		er / .	gh on
-	- Maria Cara Cara Cara Cara Cara Cara Cara		It not in hosp	oital, give street address)	d STREE	T ADDRESS				e to RESIDENCE
	Springfie:	ld State Ho	spita	L		1744	Alicean	na St.		YES NO
	NAME OF DECEASED Type or print)	Teresa Ja		Slowik Orr	stein	Last	4. DATE OF DEATH	Januar		20, Yeor
5. S	EX	6. COLOR OR RACE	7- MARRIE	D NEVER MARRIED	B. DATE OF BI			AGE (In years		YEAR IF UNDER 24 HP
	Female	White	WIDOWED	DIVORCED [	Septe	mber 23	3, 1873	85 yrs.	Months D	Days Hours Min.
100	bring most of working	g life, even it retired)	done 10b. K	IND OF BUSINESS OR INDI			or fareign cou	nfry)	12. CITIZ	EN OF WHAT COL HIR
	Housewiie	3		-		land				Unknown
13.	FATHER'S NAME				1	R'S MAIDEN N				
	Thomas Sl					gina Wi	TTK		error sceneral, Wa	_
	no, ar unknown]	R IN U. S. ARMED FOILT yes, give war or dates of		OCIAL SECURITY NO. 17.	INFORMANT	. 9 1 71		Address		
	No	-			opringi	iera no	ospitai	Record	S	
		'H [Enter only one cou	se per line f	or (o), (b), and (c). ]						ONSET AND DEATH
	PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE (o)	Bron	chopneumonia						Days
	49/X	DUE TO		•						
	Conditions, if or			_						
	gove rise to immed (o), stating the v									
	couse fost.	(c)								
ATION	C.B.S. ass	rsignificant con soc.with ci reaction.	r. Fr	NTRIBUTING TO DIATH BU St. With cere acture, right	bral ar	terios	clerosi	ONDITION GIVES	EN IN PART	1(0) 19. WAS AUTOPSY PERFORMED? YES NO
CERTIFICATION	200. EXTERNAL CAU PRIMARY () or CON CAUSE OF DEATH.	SE WAS ITRIBUTING []	6 DESCRIBE	HOW INJURY OCCURRED	(Enter nature a	finjury in Fort	For Part H of	item 18 )	-	
	20c. TIME OF INJUR		or T20d. II	NJURY OCCURRED 20e P	LACE OF INJUR	Y (Home, form	. 120f (City of	r fown)	{Coun	nty) (Stote)
MEDICAL	Hour o.m.	10	White		actory, street, of	fice bldg., etc.)			,	.,,
2	p. m. 21. I certify th	at I taak charae		emains described al	pave, held o	an Autopsi	/ [30]. Ins:	pection XI	Inquiry	, and 'n m
				auses []. Accided	erem .		tamicide [			nanner 🗍
	opinion dealing	Cooned Home	^ /	over [_]. recode	, JOIC	100 []	Tarricia E		innined in	danier
	ACTUAL	Telles -	1. 51	1000	CHIE	F MEDICAL EX	AMINER []			DATE SIGNED
	SIGNATURE		- C-K		M.D.		AL EXAMINER			- 1- 1-1-
	EXAMINER'S NAME (Type)	James T.	Mars	h, M.D.		TY MEDICAL E		~		1/20/59
720	BURIAL, CREMAT O	N. 1226. DATE THEREC	OF T	22c. NAME OF CEMETERY	OR CREMATORY		22d. LOCATIO	N (City_towar/s	מר במעואון)	(Stote)
1_!	riel	11/21/5	9	St. Stanis	laus		alti	more,	)	aryland
23.	FLENERAL DIRECTOR	S SIGNATURE CON	s.180	8 ADDRESS	A T.F. 1		NY REGISTRA	R 246. REGI	STRAR'S SIGN	
	lale o	A L	Last		4 2 4 And	DATEJA	N 21 '59		all in S.	/ CALLA
-	or Allegan the stranger of the party of the	The second second second						Name of Contract o		THE MALE CONTRACTOR

4 should be 1 0 VS ATSME 5M 2/57

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessacrate the consister, withing the word "pending" in pencil in 11em, 18. Give Pages 1, 2, and 3 to the funeral descended to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained if FUNERAL DINCETOR: Itage 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board is 15 should be used as a burial-transit permit. File pages 1 and 2 with the State Board is 15 should be used as a burial-transit permit.



CERTIFICATE OF DEA	DEAT
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	// (	$\mathbf{u}$		CERTIFIC	,,,,,	- 01 -		•			Reg. D	ist. No		
1 PLACE OF DEATH • COUNTY C:	erroll			MARYLANG	31	USUAL RESID	Mary.			institutio OUNTY			omer;	
b. CITY OR TOWN ( RURAL and give no SVicesvil		is, write		TH OF STAY IN THE		c city or t	own (If o	utside corpo	prote limits,	write Rt	JRAL ond	give ne	prest fow	n)
d NAME OF HOSPIT	AL (If not in hospital, g	ospi	oddress)			d. STREET A			7. 0		-			SIDENCE FARM?
3. NAME OF DECEASED (Type or print)	Essie		llon	Middle Sheckle	<b>5</b> '	Poole		4. DATE OF DEATH	Jar	Mont		20,		Yeor 1959
s. sex Female	6. COLOR OR RACE White	7. MARE	_	EVER MARRIED DIVORCED	B D	ATE OF BIRTH		75	9, AGE (I	years thdoy)	IF UNDER	Doys		ER 24 HRS.
10a. USUAL OCCUPATION during most of world Housewif	ung life, even if retired	done 10b	KIND OF	BUSINESS OR IN	SUSTRY		ylan	_	country)		12. CI	TIZEN C		COUNTR
13 FATHER'S NAME Stansbur	y Sheckles				1.	MOTHER'S		Barber	-					
15. WAS DECEASED EVE			SOCIAL S	ECURITY NO 17		RMANT ringfie				Adde				
PART 1. DEA  HY/X  Conditions, if a gove rise to i couse (a), stating lying couse last.	the under-	)	Bron	chopneum			THE TERMS	yehise:	TC TO	25 CY	ENIN PAI	ONS	P. WAS	BEATH S
U (IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOT	W INJURY OCCUR		of INJURY I				18 )			YES 🗌	
ZOc. TIME OF INJUR	19	While		while	foctory	, street, office	bidg., etc.	)	y or lown;		1	County)		(Stole)
1 1 '-	ot I attended the nuary 20.  (Verno( Edmund Lus	Lu	59_; _att	and that dea		Sprin	6:00		n the co treet, city of a te H	uses a r town, s DSPI	nd an t		te state	
20. BURIAL, CREMATION SEMOVAL (Specify)	Jan.23			Mt. V	1ew				tion (City)				(Stol	(0)
23 FATTERAL DIRECTOR	Woleswin	th	195	amascus	, M	id.		BY REGIST	TRAR 24		TRAR'S SI		RE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4 funeral director. may be retained by the haspital or attending physician.

TO FUNERAL DY TOR: After this certificate has been signed by the attending physician and campletely filled in by page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 sm the registrar prior to burial, cremation, ar remayal, and in any event within 72 haurs after death

VS A15 (4) 15M 9/55



			R	leg. Dist. No.			
1. PLACE OF DEATH ° COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (Who o. STATE Mary]	re deceased lived. If institutions and b. COUNTY	Residence before admission) Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykosville	3 Lyrs . Imo . 9da		ilside corporale limits, write RUR town	At and give nearest town)			
d. NAME OF HOSPITAL (If not in haspitol, give street of OR INSTITUTION Springfield State Hospi	oddress) Ltal	d. STREET ADDRESS		• IS RESIDENCE ON A FARM? YES NO-			
3. NAME OF First DECFASED (Type or print) Pearl	Middle W. P.	resgraves	4. DATE Month Of DEATH Jamua:	ry 19, 1959			
s. sex Female  6. color or race 7. Marri Widowe		March 24, 18		UNDER I YEAR IF UNDER 24 HRS Norths Days Hours Min.			
100 USUAL OCCUPATION (Give kind of work done 10b to dyring most of working life, even if retired) HOUSEWOOK	SHOWE STATE	Virginia	7 //	U.S.A.			
13. FATHER'S NAME		14 MOTHER'S MAIDEN NA	AME				
John J. Bowen		Lucy V.	Case				
15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. 5	SOCIAL SECURITY NO 17. II	NFORMANT	Address				
(Yes, give wor or dates of service)	and a	Springfield S	State Hospital 1	Records			
TO CONTRIBUTING CAUSE OF DEATH  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stoting the under lying couse lost.  PART II OTHER SIGNIFICANT CONDITIONS OF CONTRIBUTING CONTRIBUTION	Generalized no operation of the sur help the contract to be a sur	NOT RELATED TO THE TERMIN	HAL DISEASE CONDITION GIVEN	INTERVAL BETWEEN ONSET AND DEATH YOARS  IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NOTE			
21. I certify that I attended the deceased from October 20, 19 54, to January 19, 19 59, that I last saw the deceased							
ACTUAL SIGNATURE STUMMED THE THE PHYSICIAN'S FORWARD THE THE PHYSICIAN'S FORWARD THE PHYSICIAN'S	actual signature of the course and an the date stated above ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE STATE TO SPRINGFIELD STATE HOSPITAL 1/19/59  PHYSICIAN'S Edward Lusthaug M.D. Sydnagrilla Manual and						
220 BURIAL, CREMAT ON, 22b. DATE THEREOF  BENOVAL (Specify)  1-22-59	22c. NAME OF CEMETERY DI		22d LOCATION (City, 19wn, or of	Country (State)			
TO FUNERAL DIRECTOR'S SIGNATURE  AUCTION OF HALLY	Popular Charles	ME SAL DATE JAN	I O w K	AR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL D page 3 should VS A1S (4) 15M 9/SS

funeral director,

may be retain.— The haspital or attending physicion.

O FUNERAL D. OR: After this certificate has been signed by the attending physician and completely filled in by page 3 should.— elached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 1 sm the registrar prior to burial, cremation, or removal, and in any event within 72 haurs after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

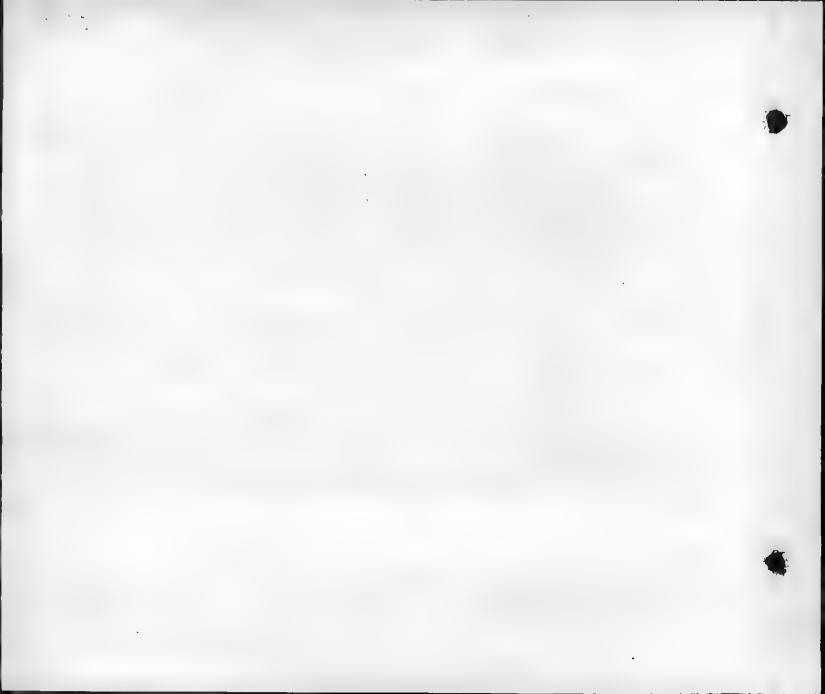
**CERTIFICATE OF DEATH** 

00484

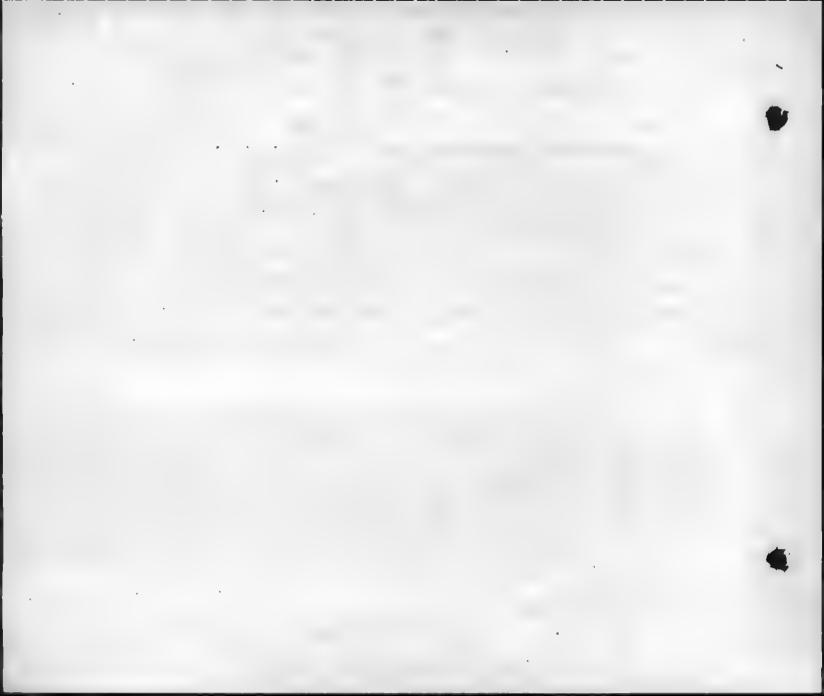
		492	CERTIFICA	ATE OF DEATH	1	Reg. Dis	t. No.	
	1. PLACE OF DEATH 3. COUNTY Carroll		MARYLAND	2 USUAL RESIDENCE (WA	ь.	If institution Residence COUNTY Frederi		
	b. CITY OR TOWN (If outside cor RURAL ond give nearest town) (Rural) Syke	sville	5mo 18days	c. city or town (if o	utside corporate fimili			
~	d NAME OF HOSPITAL (If not en		oddress)	d. STREET ADDRESS	Third St	reet.	e. IS RES DENCE ON A FARM? YES NO 1	
	3. NAME OF DECEASED (Type or print)	Fini George	Middle Edward	Revnolds	4. DAYE OF DEATH	Month	Day Year 6 1959	
	5. SEX 6 COLOR Whi	OR RACE 7. MARI	RIED NEVER MARRIED	2-11-90	9. AGE lost b	rthday) Months	YEAR IF UNDER 24 HRS Days Hours Min.	
	10c USUAL OCCUPATION (Give kinduring most of working life, ever	of work done 10b.	KIND OF BUSINESS OR INDU	STRY II BIRTHPLACE (Slove Marvla	or foreign country)	12. CITI	ZEN OF WHAT COUNTRY?	
)	13. FATHER'S NAME UNKNOWN	PAH	CN	14 MOTHER'S MAIDEN N	IAME			
	15. WAS DECEASED EVER IN U. S. A (Yes no or unknown) (If yes, give wor  Unknown)	RMED FORCES7 16. or dotes of service)		ecords-Spri	ngfield	Address State Ho	spital	
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c) ]  PART I. DEATH WAS CAUSED BY:  MMEDIATE CAUSE (o) Acute myocardial infarction  Hou							
	Conditions, if ony, which gove rise to immediate (b) Chronic myocardial infarction Years							
	couse (a), stoling the under- lying couse lost (c) Coronary arteriosclerosis Years							
1	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY Chronic Brain Syndrome associated with circulatory disturbance ORMED?  With cerebral a rteriosclerosis, with psychotic reaction  Wes I no I  200. ACCIDENT WAS UNDERLYING 1 CONTRIBUTING 10 OF CONTRIBUTING 11 CONTRIBUTING 11 CAUSE OF DEATH 18 (Enter nature of Injury in Port & or Port II of Idem 18)  UNDERLYING 11 CONTRIBUTING 11 CAUSE OF DEATH 18 (Enter nature of Injury in Port & or Port II of Idem 18)							
	20c. TIME OF INJURY Month, Hour o. m. p. m.	While		ACE OF INJURY (Home, form clory, street, office bldg, etc.	, 20f. (City or town)	) (C	ounty) (Stote)	
	21. I certify that I attend	6 19	58, , and that death	occurred of 12:3		ouses and on th		
1	ACTUAL SIGNATURE PHYSICIAN'S TRICE THE	14 hu	10		field St		ital	
	220 BURIAL CREMATION, 22b. DA	r Knopp. TE THEREOF 1. 10.159	M.D.    22c NAME OF CEMETERY O   Mt. Olivet	R CREMATORY	ille, Ma  22d LOCATION (CIT  Freder	y town, or county)	(Stote)	
	23. FUNERAL DIRECTOR'S SIGNATUR		ADDRESS Frederick, 1	24a. REC'I	D BY REGISTRAR 2	PAD REGISTRAR'S SIG	NATURE	



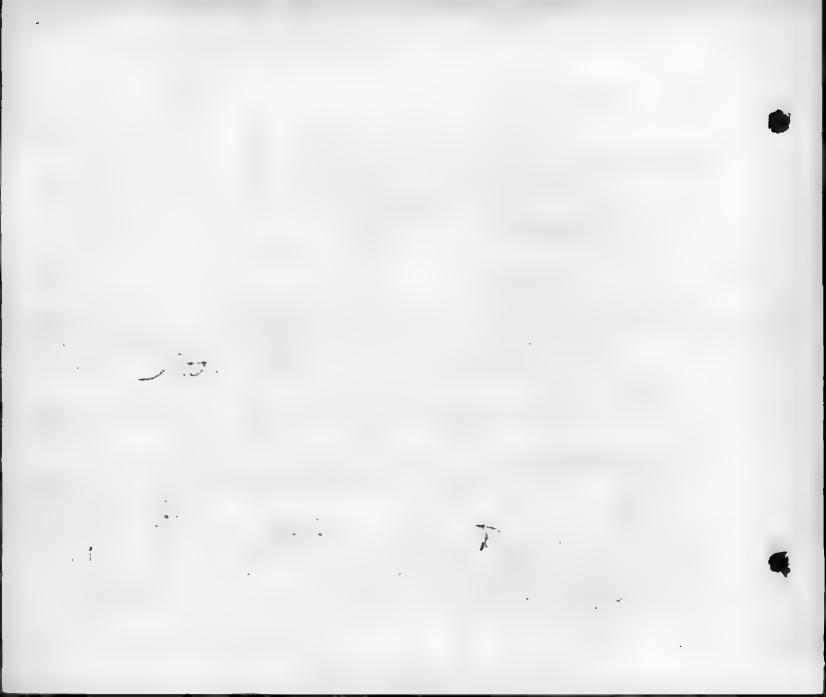
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 493 **CERTIFICATE OF DEATH** Rea, Dist. No. director, 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. COUNTY O. STATE Ġ, **b** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ondraive nearest town) d NAME OF HOSPITAL (If not in hospital, give street address) e IS RESIDENCE d STREET ADDRESS OR INSTITUTION ON A FAPM? YES NO DE NAME OF First Middle DATE Lost Month Year DECEASED OF DEATH (Type or print) nuary 19 5 6. COLOR OR RACE MARRIED NEVER MARRIED TO B DATE OF BIRTH AGE (In years lost birthday) 5. SEX IF UNDER I YEAR IF UNDER 24 HR Months Dovs Hours WIDOWED | DIVORCED | 100. USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life even if retired) guq 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address iding p CAUSE OF DEATH [Enter only one couse per line for (o), INTERVAL BETWEEN ONSET AND DEATH (b)) and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Fhat Conditions, if ony, which gove rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPS PERFORMED? YES NO T 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of item 18) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Day, Year 20d INJURY OCCURRED 20f (City or town) (County) (State) factory, street, office bldg., etc.) Hour o.m. While Not while ol work at work p. m. 1937, that I last sow the deceased 21 I certify that I attended the deceased from alive on ADDRESS (Street, city or fown, stole) DATE SIGNED **ACTUAL** SIGNATURE DIR PHYSICIAN'S FUNERAL NAME (Type) 220 BURIAL CREMATION. 72b DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 72d LOCATION (City town, or county) (Slate) REMOVAL (Spec fy) 0 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246 REGISTRATE SIGNATURE 24g. REC'D BY REGISTRAR VS A15 (4) 15M 10/57



	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	494 CERTIFICATE OF DEATH Reg. Dist. No.
	1. PLACE OF DEATH  COUNTY  COU
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Syklsville  5 Me. 5 d.  GENGTH OF STAY IN 1b  C CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Figure 1 and 3 and 3 and 4 and 5
15	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Springfield Hospital  R. F. D.  e. IS RESIDEN ON A FARI YES \sum NO
6	3 NAME OF DECEASED (Type or print) Clavence & W Rogers, Sr. DEATH Tax. 3/ 19
	5. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH  WIDOWED DIVORCED May 4. 1885 (73,773) yrs. 8 27 Hours M
deoth.	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Dairy—  Dairy—  11. BIRTHPLACE (Stole or foreign country)  12 CITIZEN OF WHAT COU
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	13. FATHER'S NAME William H Rogers 14. MOTHER'S MAIDEN NAME  Emily ?
2 40	15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT NO - None None Mks. Havy Mossburg (daugater) (Teymoutown
ent within	IB CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o) AVIZVIOSCLETCIC CAVATOVASCULAR disease  1 X DUE TO
nd in any ev	Canditions, if ony, which gave rise to immediate couse (a), stoting the under-lying couse last  (b) Ganarelized a vie vio sclerosis  DUE TO  Lying couse last  (c) Didbetus wellitus
removol, o	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTO PERFORMED CHIPOLIC. Drain Syndrome associated with Sourile brain YES NO OR ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
emation, or	UF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED Hour o. m.  40 P. m.  19 While Not while of wark of war
burial, cr	21. I certify that I attended the deceased from and 15, 19 18, to 124, 31, 19 17, that I lost saw the decease of alive on 124, 30, 1957, and that death occurred of Life AM, from the causes and on the date stated of
origin to	ACTUAL SIGNATURE Jaco Fusabell MD. Sprifull fle 4 Hospilal Sylcein
gistror	PHYSICIAN'S YASUO TAKAHASHI Springfield 37ste Hospital Syks
the rec	Burial 2/4/59  22c. NAME OF CEMETERY OR CREMATORY  Darnestown Church  Darnestown, or county)  Darnestown, Maryland
4)	23 FUNERAL DIRECTOR'S SIGNATURE ROLLIT CE Sunfling - Chil. Balling Will DATE FFR 1 59 1 17 Faces.



á



Zion Cemetery

Littlestown. Pa.

ADDRESS

e 15 PER DEN E

ON A FARM

YES NO F

Year

19 J

Hours

ONSELAND DEATH

PERFORMED? NO R

(Stote)

and in my

DATE SIGNED

Charlesville Frederick Co. Md.

24p. REC'D BY REGISTRAR

DATE JAN 2 6 '59

246 REGISTRAR'S SIGNATURE

arthur & Thurs

ZH

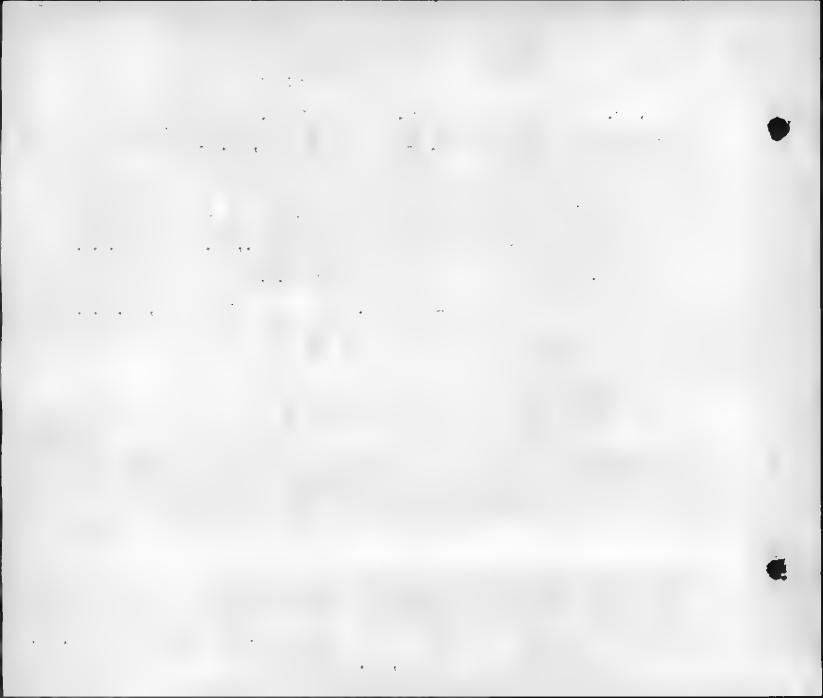
Days

U.S.A.

VS A1SME BM 2 57

Burial

1/27/





■ by be retwiced by the haspital ar attending physician.

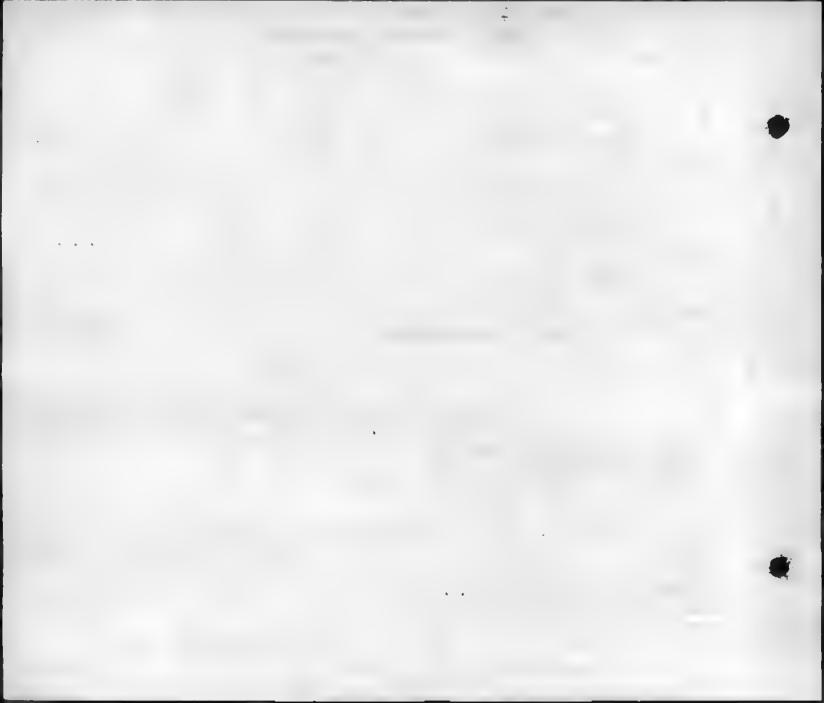
FUNE ■ 10R: After this certificat has been signed by the ottending physician and completely filled in by uneral director, page 3 should be detached far use as the burial-transit ■ mit. Then please remove carbon pagers. Pages 1 and 2 should be filled with he registrar prior to burial, cremation, ar removal, and in any event within 72 hours ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

	10		
VS 15A	A15	(4) 55	

~ 11

L		2 277	- Cantin		IL OI DEATH	•		Reg. Dist.	No.	
	1. PLACE OF DEATH			2 USUAL RESIDENCE (Wh	ere deceased		n Residence	before admission)		
1	Carroll		MARYLA	AND	Maryland b. COUNTY			-Ba	Baltimore	
Γ	b. CITY OR TOWN (If outside corporate lim	its, write	c. LENGTH OF STAY IN 1b c CITY OR TOWN (If autside corporate limits, write RURAL and							
1	Sykesville (Rural	Sykesville (Rural) 23y 10m 4d Baltimore					*			
	d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION	give street	oddress)		d STREET ADDRESS				e. IS RESIDENCE ON A FARM?	
	Springfield State	Hosp	ital		Unknown				YES NO TO	
Ī	3. NAME OF FI	rst	Middle		Lost	4. DATE	Month		Day Yeor	
1	(Type or print) Ma	ry	Theresa		Schatz	OF DEATH	Januar	v 26.	19 59	
1	5. SEX 6. COLOR OR RACE	7. MARE	RIED A NEVER MARRIED	B.	DATE OF BIRTH	9	AGE (In years II	FUNDER 1	YEAR IF UNDER 24 HRS	
ł	Female   White	WIDOW	ED DIVORCE D		May 31, 1877		last birthday)	Months D	ays Hours Min	
Ī	100. USUAL OCCUPATION (Give kind of work during most of working life, even if retired	dane 10b.	KIND OF BUSINESS OR	INDUSTI	TY 11. BIRTHPLACE (Stote of	or foreign cou	ntry)	12. CITIZ	EN OF WHAT COUNTRY	
1	Housewife	"	-		Maryla	nd			U.S.A.	
Ī	I3, FATHER'S NAME				14 MOTHER'S MAIDEN N			1		
	Patrick Doughterty				Jane M	yer				
ΝĒ	15. WAS DECEASEDEVER IN U. S. ARMED FOI		SOCIAL SECURITY NO.	17. INF	ORMANT		Addre	11		
L	No -		_		Springfield	Hospit	al Record	ds		
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) ]							INTERVAL BETWEEN		
Т	PART I. DEATH WAS CAUSED BY: Bronchopneumonia							Days		
Т	420.0 DUE TO									
	Conditions, if ony, which ) Arteriosclerotic heart disease							Years		
	gove rise to immediate DUE TO									
	lying couse lost.									
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY									
-	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19.  Manic depressive reaction, mixed type.  20a ACCIDENT WAS UNDERLYING D 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING D CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							PEREORMED?		
	20a ACCIDENT WAS UNDERLYING   20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port II or Port II of Item 1B.) OR CONTRIBUTING   CAUSE OF DEATH   (IF EITHER, NOTIFY MEDICAL EXAMINER)									
H	20c. TIME OF INJURY Month, Doy, Ye	or 20d. II	NJURY OCCURRED 20	De PLAC	E OF INJURY (Home, farm,	20f (City o	r town)	1Co	unty) (Sigle)	
	20c. TIME OF INJURY Month, Doy, Ye Hour o.m.	While of wor	Not while	facto	ry, street, affice bldg., etc.	1		(44	//	
ľ	21. I certify that I attended the				10 El To	70110222	26 50		st saw the deceased	
ı	alive on January 26,	aeceas			ccurred of 3:50P	nuary		that I la	st saw the deceased	
Т	dive on	t) 12	22, and that a	leorn o			The causes on el, city or town, st		date stated above	
	ACTUAL TO MUNICIPAL J	ust	team		0		ate Hospi		7 /07 /5	
ı	SIGNATURE C.C.			M.	o Springile	100	a 06 1100D.	Lval	<u>-1/4/2</u>	
	PHYSICIAN'S Fdmund Lus	thaus	, M.D.		Sykesvill	e, Mar	yland			
2	DENIOVAL (SPECIF) 226. DATE THERECO	59	22c. NAME OF CEMETE	ERY OR	REMATORY	22d LOCATIO	ON (City town or	county)	Trel (5190)	
2	23. FUNERAL DIRECTOR'S SIGNATURE	* /	_ADDRESS	1	24g, REC'D	BY REGISTRA	AR 24b REGIST	RAR'S SIGN	IATURE	
+	Turley Turneral Ho	ne-	Calonarde	oi	Med. DATE JAN	2 9 59	(7)	MIT	MARKET	
E		-								



	100			, 	Reg. Dis	t, No.		
	PLACE OF DEATH Carroll	MARYLAND	OTON			inore odmission)		
	b. CITY OR TOWN (If autitide corporate limits, write RURAL and give nearest town)  Sykesville	vears 2 mo	Baltimor		its, write RURAL and g	ive nearest town)		
	d NAME OF HOSPITAL (If not in hospital, give stre	eet oddress)	d STREET ADDRESS			IS RESIDENCE ON A FARM?		
	Springfield State	Hospital	719 Rams <b>a</b> y	St.		YES NO 🖸		
	3. NAME OF DECEASED (Type or print) Jacob	· Middle Henry Se	ifert	4. DATE OF DEATH	Month	8 19 59		
			DATE OF BIRTH		(In years IF UNDER			
	Male White wood	OWED DIVORCED	5-26-1867	9	] Asr	Days Hours Min.		
	100 USUAL OCCUPATION (Give kind of work done) 10 during most of working life, even if retired) Laborer	06. KIND OF BUSINESS OR INDUSTI	Pennsylv			ZEN OF WHAT COUNTRY		
	13. FATHER'S NAME		14 MOTHER'S MAIDEN N			D11		
1	Jacob Seifert		Georgean	ma (Seif	ert) Cars	on		
/	15 WAS DECEASEDEVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give wor or date of service)		ormant s. Eleanor	,	19Manse	•		
	THE CARRE OF DEATH (T-1)		2. Treamor	raik I	ST CTITOLE			
	PART I DEATH Enter only one couse per PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		lusion			ONSET AND DEATH		
	420./ DUE TO		- C		Discoso	V		
	gave rise to immediate DUE TO	<u>rterioscleroti</u> e <b>h</b> eralized Art			Disease	Years		
	PANT H OTHER SIGNIFICANT CONDITION CBS associated with	s contributing to DEATH BUT No.	of metabol	I SM . OT	OWTH OF	PERFORMED		
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	Richae Hold Traviale Cookies		,	· · ·	VES NOTE		
	ā Hour o.m. Wh	facts.	E OF INJURY (Hame, farm, ry, street, office bldg., utc.)	20f. (City or town	n) (C	ounly) (State)		
	21. I certify that I oftended the deceosed from Oct. 28., 19.55, to Jan. 8, 19.59, that I last sow the deceosed alive on Jan. 8, 19.59, and that death accurred at 6:450M, from the couses and on the date stated above.  Springfiable (State of the order of the state of th							
	220 BURIAL, CREMATION, 22b. DATE THEREOF BURIAL (Specify) 1-12-59	Mt. Olivet C		22d. LOCATION (C	ily, town, or county)	(Stote)		
	23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS			24b REGISTRAR'S SIG	NATURE		
	William Cools Inc 127	7 St Poul Street	+ JAN 1	2 '59	Cirching S. T.	taud.		

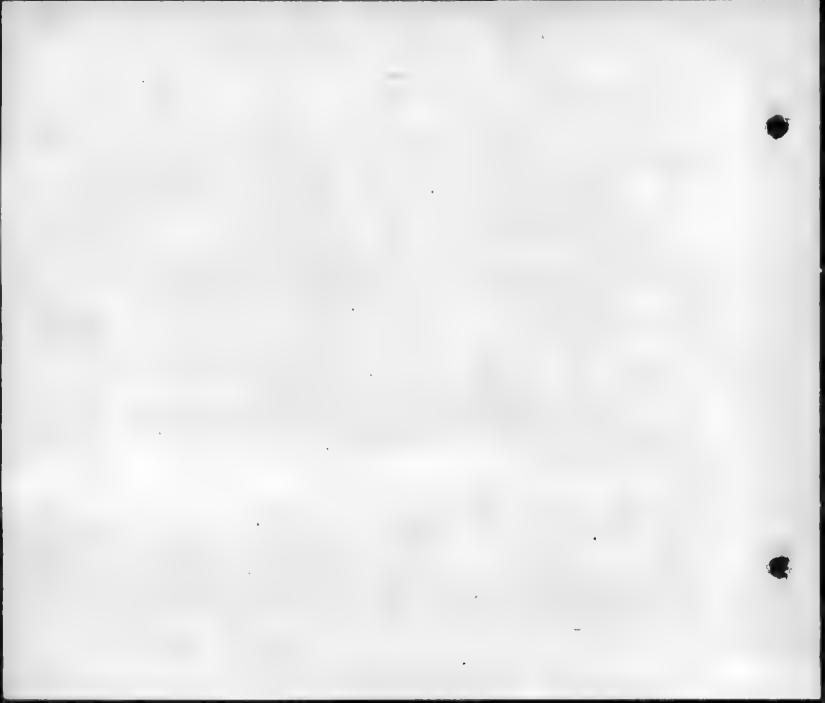
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 the haspital or attending physician. may be retained the haspital or altending physician.

TO FUNERAL I OR: After this certificate has been signed by the attending physician and campletely filled page 3 should be detached for use as the burial-stransit permit. Then please remove carbon papers. Pages 1 should be detached for use as the burial-stransit permit. Then please remove carbon papers. Pages 1 the constant arise to burial, cremation, or removal, and in any event within 72 pears after death.

uneral director, Id be filed with

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TO HOSPITAL OR VS A15 (4) II 5M 9/5II



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11/1492 500 **CERTIFICATE OF DEATH** Reg. Dist. No. filed with 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) · COLNIA b. COUNTY MARYLAND Carroll Maryland b. CITY OR TOWN (If outside corporale limits, write LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pe RURAL and give nearest town) 60yrs. TO Rural Sykesvil Baltimore d NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO none 2. NAME OF Middle 4. DATE Lost Month Day Year filled des 1 DECEASED Andrew DEATH (Type or print) Sherwood 9 1959 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER TYEAR IF UNDER 24 HRS completely papers. Pag 5. SEX B. DATE OF BIRTH 9. AGE (In years lost birthday) Manths Dovs Hours Min. Male White WIDOWED [7] DIVORCED T Unknown 88-? 100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY? deoth. during most of working life, even if retired) Maryland and corbon A ÆU offer 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME unknown unknown remove 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address no Records Springfield State Hospital none offending 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN 24 hours PART I DEATH WAS CAUSED BY. Bi-lateral Pneumonia DUE TO þ permit. ony Conditions, if any, which gave rise to immediate DUE TO couse (a), stating the underlying couse last. (c) Define 1 Cla president conditions contributing to death but not related to the terminal disease condition given in part 16) 19 was autopsy performed? YES NO T 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port If of item 18.) 20e. PLACE OF INJURY IHome, form, 20c, TIME OF INJURY Month. Doy, Year 20d INJURY OCCURRED 20f (City or town) (County) (Stole) factory, street, office bldg , etc.) Hour o.m. While Not while at work at work 21. I certify that I attended the deceased from July 55 Jan. 9 ..., 1959, that I last saw the deceased \_, 19\_\_\_\_, to\_\_ alive on Jan. 9 , and that death accurred at 6:25M, from the causes and an the date stated above. ä ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Springfield State Hospital FUNERAL DI PHYSICIAN'S Walter Knopp. M.D. NAME (Type) 220 BURIAL CREMATION 220 DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d LOCATION (City town, or county) bage 0 ADDRESS 23 FUNERAL DIRECTOR'S SIGNATURE 24b REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR has been I go well



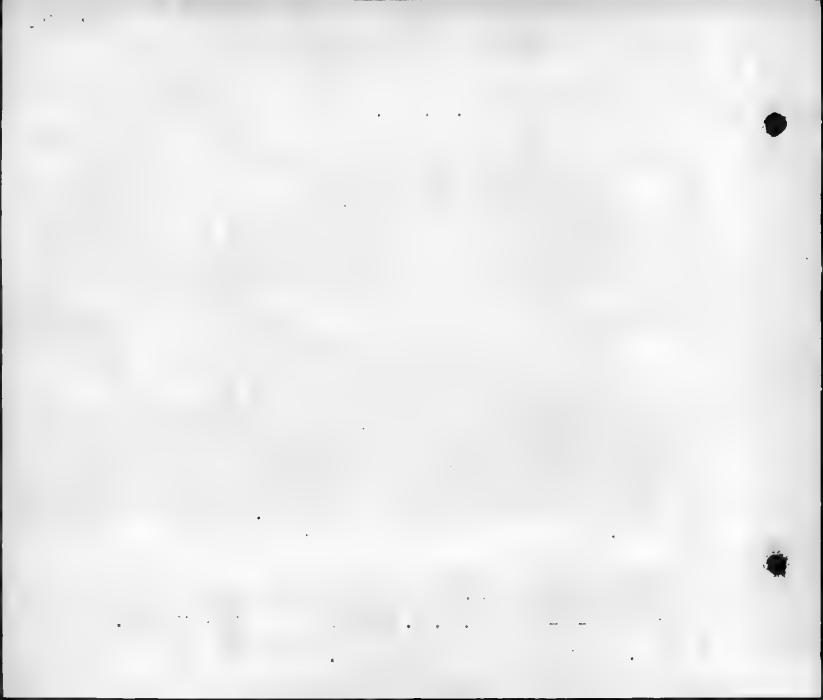
	10.10							Kall: DIZ	. 140.			
) PLACE OF DEATH 6. COUNTY					2. USUAL RESIDENCE	Where decease	d lived If institute b. COUNTY	on: Residenc	e before adi	mission)		
Carro	Carroll					Larvland Lashington						
b CITY OR TOWN (I RURAL and give no	If outside corporate limi earest town)	ls, write	c. LENGTH OF STAY IN	Y IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest t						own)		
	cesville		5vr-9mo-17d	avs					×.			
d NAME OF HOSPIT OR INSTITUTION Spring	rfield Stat	e Ho	Loddress)		d. STREET ADDRESS	ton Cou	inty Home		101	RESIDENCE N A FARM?		
3 NAME OF						To said						
DECEASED (Type or print)	Ester.	st	Ashby		Shith	4. DATE OF DEATH	Mon	ith.	2 <sup>9</sup>	Yeor 19 59		
5. SEX	6 COLOR OR RACE	7 MAR	RRIED NEVER MARRIED	□ 8	DATE OF BIRTH		9. AGE (In years		YEAR IF U	NDER 24 HRS		
Male	White	WIDOV		_	81867		lost birthdoy) 91 yrs.	Months	Days Hou	rrs Min		
100 USUAL OCCUPATION	ON (Give kind of work	Jone 10b	. KIND OF BUSINESS OR	INDUST	RY 11 BIRTHPLACE (SI	ote or foreign c	ountry)	12. CITI:	EN OF WE	AT COUNTRY?		
	king life, even if relired											
Farming Tarming					Maryla							
					14 MOTHER'S MAIDE							
Adolphus						abeth S						
	R IN U. S. ARMED FOR [11 yes, give wor or doles of t		SOCIAL SECURITY NO.	17. IN	FORMANT		Add	ress				
urk own	www.date		unknewn	Re	cords Sprin	gfield	State Ho:	omital				
18 CAUSE OF DEA	ATH [Enter only one co	use per l	line for (o), (b), and (c).]							BETWEEN		
	PART I. DEATH WAS CAUSED BY: Anterioseleratic cardiovascular disease									ONSET AND DEATH		
			Terloscleret	1C	cardiovascu	lar dis	erse		1/3	ауз		
Mr - 50. 17	4 d d DUETO											
Conditions, if o									3			
gove rise to i couse (a), stoling												
lying couse lost.												
Ch TENT ILON	Ch - SAI I GODER SIGNIFICANT FOUND HORS SOMETIBLE HAND TO SEATHER THORITIES TO THE TERMINAL DISEASE FOUND TO THE MASS AUTOPSY											
TY must mit is a	a reith car	170	hrain diseas	0	with neveho	tic res	et = on	, 8,		REFORMED?		
Chronition ON ACCIDENT WAS CONTRIBUTION OF CONTRIBUTION OF FETTHER, NOTIFY	AS UNDERLYING []	20b DE	SCRIBE HOW INJURY OCC	URRED	(Enter noture of injury	in Port I or Por	t II of item 18.)		1	<u> </u>		
	MEDICAL EXAMINER											
20c TIME OF INJUR Hour o m. p. m.	Y Month, Doy, Yes	or 20d.	INJURY OCCURRED 2	De PLA	E OF INJURY (Home, f	arm, 20F (City	or town)	n) (County) (St				
Hour o m.	19	While	e Not while	foct	ory, street, office bldg.,	elc )			•			
				,		- i		0				
21. I certify th	21. I certify that I attended the deceased from August, 19_5, to Jane 28, 19_58, that I last saw the deceased											
المستقد alive on	28/	, 19,	<u>58</u> , and that d	leath :	accurred at 6:55	M, fra:	n the causes o	and an th	e date st	ated abave		
	1111111	//	110			ADDRESS (S	Ireel, city or lown,	stole)		DATE SIGNED		
ACTUAL	races	RU	us na	M	n Shrina	field S	tate Hos	pital				
0101111111			1001					<b>^</b>				
PHYSICIAN'S NAME (Type)	Walter Kno	nn.	MaDa /		Sykes	ville.	Maryland					
220 BURIAL, CREMATIC		-	22c NAME OF CEMETI	FRY OR			TION (City, town,	or county)		Stole)		
Buria Pecify)		•			metery	Cì	ewsvill	e Md	• (:	otose1		
23 FUNERAL DIRECTOR	'S SIGNATURE		ADDRESS		24a R	EC'D BY REGIS	TRAR 245. REGI	STRAR'S SIG	NATURE			
Scott F. 1	Minnich &	So	n Hagerst	OWn	Md . DATE	FFR 2 '5	3	9	1 .			
					DAIL	HU &	· ·	- X	Ev			

may be retained by the haspital or attending physician.

TO FUNERAL D. FOR: After this certificate has been signed by the attending physician and campletely filled in by page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

uneral director, old be filed with

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

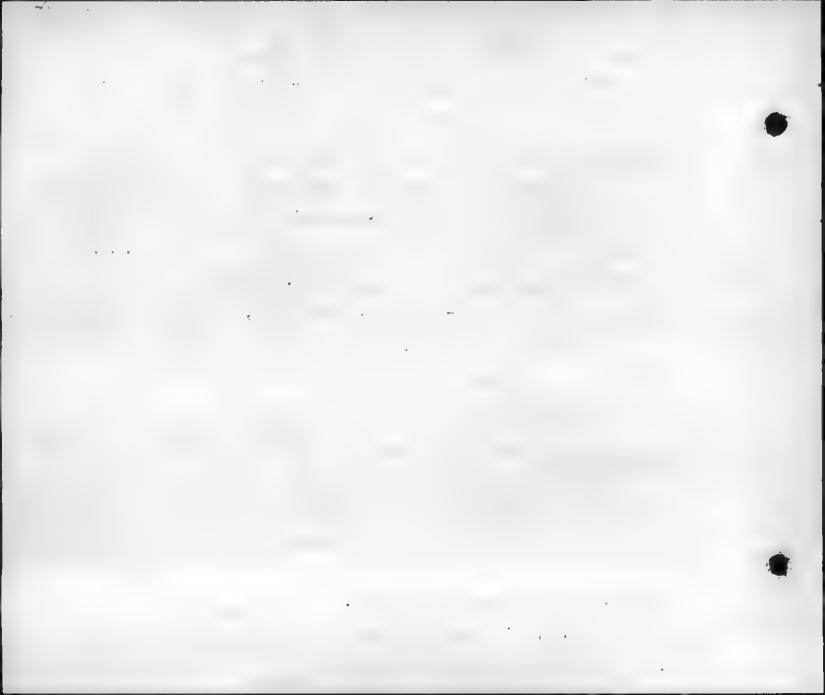
CERTIFICATE OF DEATH

502

Par Dist No.

00494

					Keg. Dist. 140.		
1. PLACE OF DEATH			2. USUAL RESIDENCE (M	there deceased lived. If institut	ion: Residence before admission)		
	roll	HALF AND	Maryla	b. COUNT <sup>*</sup>	Carrol1		
b. CITY OR TOWN RURAL and give	(If outside corporate limits, write nearest town)	c LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, write			
Rural Ta	neytown	20 years	Rural	Tanevtown			
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital, give stree	et oddress)	d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO.		
3 NAME OF DECEASED (Type or print)	Fini Harry	Middle Thomas	losi Smith	4. DATE Mo OF DEATH TRIBE	nth Day Year ary 10. 1959		
5. SEX	6. COLOR OR RACE 7. MA	RRIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE Un vents	IF UNDER 1 YEAR IF UNDER 24 HRS		
Male	White WIDOV	VED DIVORCED	June 20, 188	lost birthday)	Months Doys Hours Min		
10a USUAL OCCUPAT	ON (G ve kind of work done 10t	. KIND OF BUSINESS OR INDU	STRY 11 BIRTHPLACE (Stot	e or foreign country)	12. CITIZEN OF WHAT COUNTRY		
during most or wo	riting life, even if retired)			*			
Antique	deater		Maryland  14 MOTHER'S MAIDEN	NAME	U.S.A.		
	** 0 411		_				
	as H. Smith	and the second second		Shoemaker			
[Yes, no. or unknown]	ER IN U. S. ARMED FORCES? 16   Ill yes, give wor or dotes of service}	S. SOCIAL SECURITY NO. 17	NFORMANT	Ade	dress		
no		84-10-4117 M	rs. Walter Su	ith, Taneytown	. Maryland		
	ATH [Enler only one couse per		0		INTERVAL BETWEEN		
PART I DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	orebus va	ocular i	accident)	ONSET AND DEATH,		
X	DUE TO			,			
Conditions, if	Conditions, if ony, which) Broscolo Buches						
gove rise to	immediate (		Jenewas	me.	a acayo		
couse (o), stating	ine under-	,					
	, 101-	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM	UNIAL DISEASE COMPLETION OF	VEN IN PART 1(a) 19 WAS AUTOPSY		
PART III. OT		COLVANISORING TO BEATTH BOT	THO KEDIGO TO THE TERM	MINAL DISEASE CONDITION OF	PERFORMED?		
	AS UNIOCOLVING ET 205 DE	SCRIBE HOW INDIVIDUOUS OCCURRE	D 15-1	P-11-P-11-67-101	YES NO P		
O THE BITHER, NOTE	G LI CAUSE OF DEATH Y MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in	ron s or ron il or nem ia.)			
ZOc. TIME OF INJU Hour o. m. p. m	While		ACE OF INJURY (Home, far ctory, street, office bldg., et	m, 20f (City or town)	(County) (State)		
21. I certify t	hat I ottended the decea	sed from lase 3	19.59.10	au 10 195	2, that I lost sow the deceased		
olive on	CLM 8 . 19.		occurred of 6 A	M from the course	and on the date stated above		
1		east	Occorred of He-2%	ADDRESS (Street, city or town,			
ACTUAL C	· Omelle	- Mariandu.	7000	The same of	1 / / / / /		
SIGNATURE	, toward con-	- Interespendent	M.D. Larrer	J-1-0-bellesteS_jl.1	10 1 11019		
PHYSICIAN'S NAME (Type)	E. Ambler Thomp	son, Taneytown	, Md				
220. BURIAL, CREMAT	ON, 226 DATE THEREOF	22c. NAME OF CEMETERY O	R CREMATORY	22d. LOCATION (City, lown,	or county) (Slote)		
REMOVAL (Specify Burial	Jan.13,1959	Reformed Ceme	eterv	Taneytown, N			
23. EUDIERAL DIRECTOR	S SIGNATURE	ADDRESS			STRAR'S SIGNATURE		
C.O. Fug	Turke Son	Tenoriton Man-			- / -		
O O O T. M.B.	2 or DOII	Taneytown Mary	TATIO NAIS	826 2 555	Titling & Hansed		



22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

1217 St. Paul Street

Baltimore Cemetery

27d LOCATION (City, fown, or county)

24a, REC'D BY REGISTRAR

DATE JAN 6

Baltimore

24b REGISTRAR'S SIGNATURE

Cother S. France

Maryland

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22a. BURIAL, CREMAT ON, | 22b DATE THEREOF

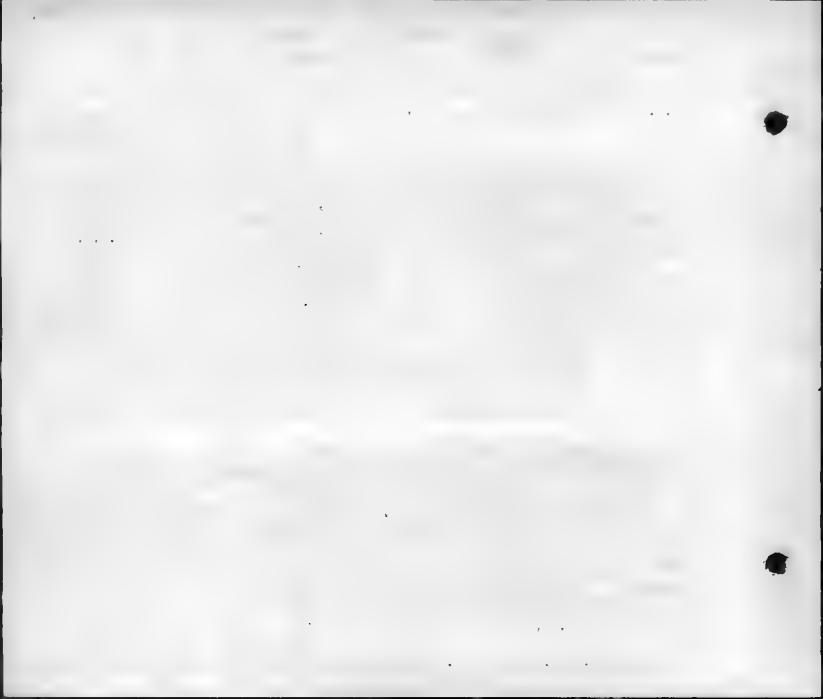
William Cook. Inc.

23. FUNERAL DIRECTOR'S SIGNATURE

Jan. 6.1959

Page

25



22¢ NAME OF CEMETERY OR CREMATORY

Cemetery

H111

Hagerstown

Rose

**ADDRESS** 

22d. LOCATION (City, fown, or county)

246 REG STRAR'S SIGNATURE

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24g. RECID BY REGISTRAR

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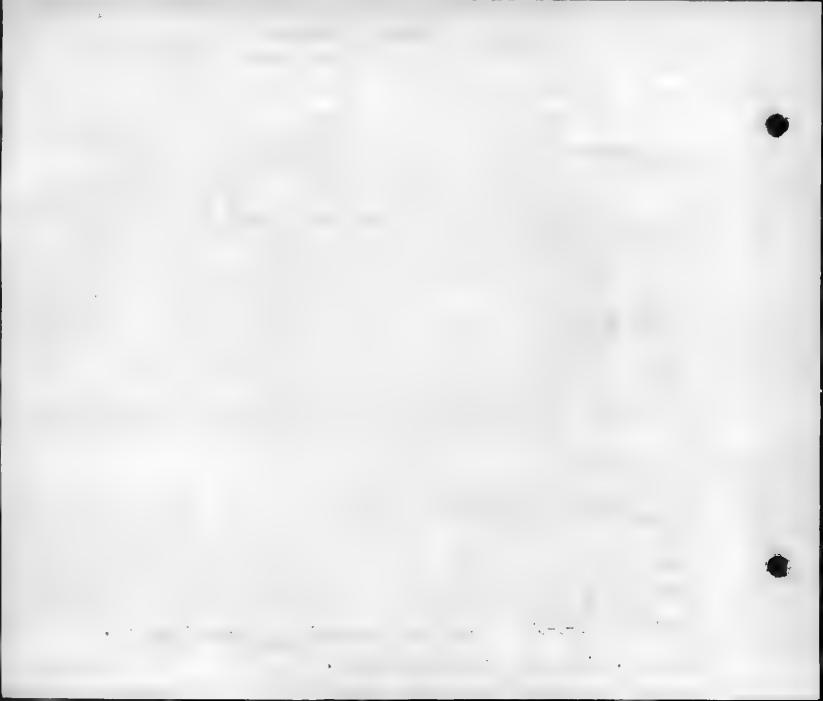
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NAME (Type) 220 BURIAL CREMATION.

23 FUNERAL DIRECTOR'S SIGNATURE

22b. DATE THEREO!

Minnich & Son



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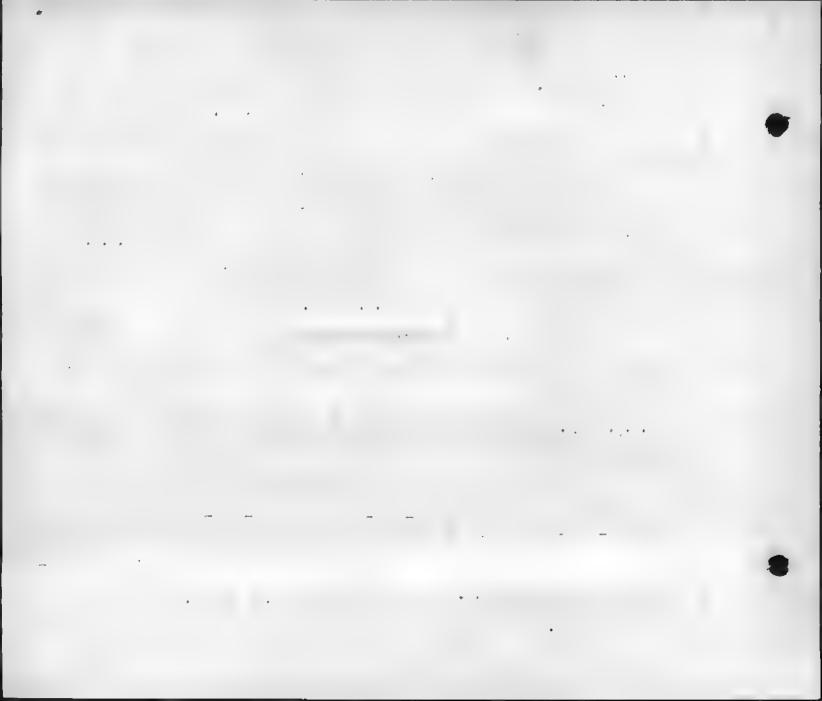
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

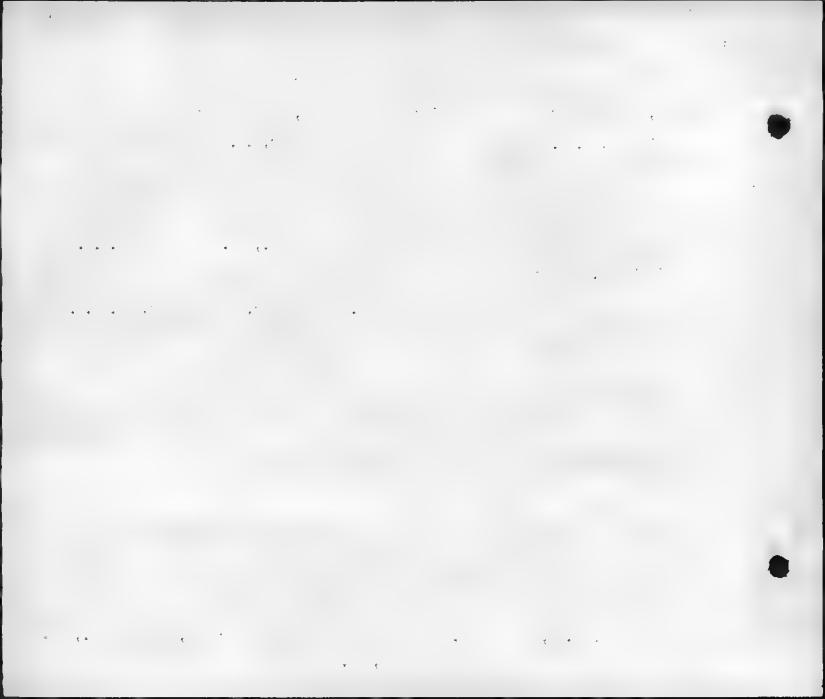
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SOE MEDICAL EXAMINER'S C	CERTIFICATE OF	DEATH
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Reg. Dist. No.

	-	-								
•		PLACE OF DEATH	Carrol1	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution o. STATE Mary land b COUNTY	n: Residence before admission)  CArroll				
1	ь		outside corporate firm s. write RUEAL	NAME OF TAXABLE PARTY.	c. City OR TOWN (If outside carporate limits, write RU					
×.		ural, West		Life	Rural, Westminster					
	_			n hosp tal, give street address)	d STREET ADDRESS Westminster, R.D.2 (Union Mills)  ON A FARM? YES NO					
	We	estminster	, R. D. 2 (Un	ion Mills)						
	- (	NAME OF DECEASED (Type or print)	ZDA	Middle MA V	STEWARD DEATH JAN	9 1959				
	5. S	SEX	6. COLOR OR RACE 7. M	ARRIED   NEVER MARRIED	DATE OF STRTH 9. AGE I'm yours IF	UNDER TYPAR IF UNDER 24 HAS				
		Female	White wo	OWED TO DIVORCED	12/19/1878 80 m	onths Days Hours Min.				
	10o.	USUAL OCCUPATIO	N (Give kind of work done)	Ob KIND OF BUSINESS OR INDUST	(RY 11 BIRTHPLACE (State or Foreign country)	12. CITIZEN OF WHAT COUNTRY?				
	He	ousewife -		In her own home	Carroll Co., Md.	U.S.A.				
	13.	FATHER'S NAME	II Caasas		14. MOTHER'S MAIDEN NAME					
	15		H. Feeser	16. SOCIAL SECURITY NO. 117	Barbara Baughman	at directal to 2				
	[Yes,		(If yes, give war or dates of service)		Address Address	HA D D 2				
			M. (Sutur poly page court page	The second second second	rs. Emma Feeser, Westminster					
		18. CAUSE OF DEATH [Enter only one couse per line for (u), (b), and (c).]  PART 1. DEATH WAS CAUSED BY:  ONOTE AND DEATH  ONOTE AND DEATH								
		IMMEDIATE CAUSE (a) CONDINARY BECFUSION								
		Conditions, if any, which and								
		gave rise to immedital, stating the u	ote couse							
		coure lost.	(c)	- AL -	th CDFAP the transform to the substitution to an experience to the substitution to the					
	Ž	PART II, OTH	ER SIGNIFICANT CONDITION	IS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM NALD SEASE CONDITION GIVEN	IN PART 1(a) 19. WAS AUTOPSY PERFORMED?				
, 1	Ž			White-trans-		YES NO NO				
	CERTIFICATION	20g. EXTERNAL CAU PRIMARY D or CON CAUSE OF DEATH.	TRIBUTING ()	CRIBE HOW INJURY OCCURRED. (	Enter nature of injury in Fart L or Part II of Item 18 )					
	MEDICAL	20c. TIME OF INJUR		20d. INJURY OCCURRED 20e PLA	CE OF INJURY (Home, form, 120f. (City or town) ory, street, office bidgs, etc.)	(County) (Stole)				
	MEC	Hour e, m, p, m,		While Not while at work of work	, , , , , , , , , , , , , , , , , , ,					
		21. I certify the	at I taak charge of t	he remains described abo	ive, held an Autopsy 🔲, Inspection 🔯	Inquiry X and in my				
		opinion death/esulted fram: Natural causes . Accident . Suicide . Hamicide . Undetermined manner								
		ACTUAL	· h	m 1)		DATE SIGNED				
		SIGNATURE	mis -	_M.D. CHIEF MEDICAL EXAMINER	. 1- /					
		EXAMENER'S NAME (Type)	TAMES T	MARCH	ASSISTANT MEDICAL EXAMINER  DEPUTY MEDICAL EXAMINER	19/59				
	220	BURIAL, CREMATION	225 DATE THEREOF	22c. NAME OF CEMETERY OR	CREMATORY 22d LOCATION (City, lown, or c	county) (Slote)				
		Buria1	Jan. 12, 1959	St. Marys Cen						
	23,	PUNERAL DIRECTORS	SIGNATURE THE	Littlestown,	Pa	AR'S SIGNATURE				
1	_/	Munu	NIN JUL	THE CHESCONII	DATE TAN 1 2 "9	La France				

THE ITEM HEDICAL ENAMINER: This certifical should be executed within 24 hours after death. If any delay is necessary, please execute the content of the forest part of the forest property of the forest property of the forest property of the forest property. The forest property of the forest propert VS ATSME 5M 2 57





L	CERTIFICATE OF DEATH  Reg. Dist. No.											
1. PLACE OF DEATH CATTOLL				MAR	<b>CAND</b>	2 USUAL RESIDENCE (Where deceased lived if institution: Residence before o o. STATE Maryland b. COUNTY Balto.C1						ion)
	b. CITY OR TOWN RURAL and give Sykesv:		ts, write	2yrs.lmo		c. CITY OR TOWN (H o		prote limits, write RL	JRAL and	give nec	rest lowr	1)
	OR INSTITUTION	PITAL (If not in hospita), g field State				d STREET ADDRESS 4532 Mari	ble H	all Rd.				FARM?
3	NAME OF DECEASED (Type or print)	Dewey		Emory		Wooden	4. DATE OF DEATH	Mont Janua		6,		Year 19 59
5	sex Male	6. COLOR OR RACE White	7 MARR	DED DIVORCE		May 10, 1898		9. AGE (In years last birthday) 60 yrs.	Months	Doys Doys	Hours	Min
10	during most of we	TION (Give kind of work in orking life, even if retired STATE	tone 10b	KIND OF BUSINESS (	OR INDUS	TRY 11 BIRTHPLACE (S1010 Maryland	or foreign c	ountry)	12. CI		S.A.	COUNTRY
13	Frankl:	in Wooden				Bertie Se		ŝ				
15	NO NO	VER IN U. S ARMED FOR		213-07-85		Springfie	ld Ho	spital Re		3		
		EATH (Enter only one co EATH WAS CAUSED BY IMMEDIATE CAUSE (o DUE TO	Br Ar	onchopneur	nonia	heart diseas	ie.			INTE	PYAL BE ET AND Days	DEATH 3
NO	gove rise to immediate couse (a), stating the under- lying couse lost.  DUE TO  (c)  Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY											
CERTIFICATION	Huntington's chorea with psychotic reaction.  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER;  PERFORMED? YES NO  P											
MEDICAL	20c TIME OF INJU Hour a.m p. m	10	While of work	Nat white at work	20e. PL/ fac	CE OF INJURY (Home, farm, tory, street, affice bldg, etc.	20f (Cit)	r or town)	(	County)		(State)
	21. I certify olive on Ja  ACTUAL SIGNATURE CONTROL OF THYSICIAM'S NAME (Type)		12 De	1 Cam	death		_M, from ADDRESS (S ld St	n the causes or freet, city or lown, s ate Hospi	nd an t	iast sa he dat	the state	deceased abave.  ATE SIGNED  159
	O BURIAL CREMATI RÉMOVAL (Specif STATEMENT DIRECTO	X Jang	-59	ADDRESS	AA I	CREMATORY  210 C	15	TION (City, town, of	MA	21/	(Stote	- MC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4 TO FUNERAL DE TORK: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remays\_carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death. VS A15 (4) ISM 9755

uneral director,

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VS A15 (4) 1SM 10/57

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Rea. Dist. No.

		PLACE OF DEATH O. COUNTY AMARYLAND	a. STATE Maleflase b COUNTY	ence before admission)
	b	b. CITY OR TOWN (If autside corporate limits, write RURAL and five negrets town)  2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	c. CITY OR TOWN Us gotsude corpolate limits, write RURAL on	d give nearest town)
	d	d NAME OF JOSP TAL (If not in hospital, give street address) OR INSTITUTION "Private home"	3/20 St Paul d	e. IS RESIDENCE ON A FARM? YES NO
	C	NAME OF DECEASED (Type or print) AMAGE Middle MI	1. DATE Month OF DEATH OF DEATH	28 1959
	5 5	SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. WIDOWED DIVORCED 1	ATE OF BIRTH  9/AGE (In years   IF UND    Months  Arts Of BIRTH  9/AGE (In years   IF UND    Months  Arts Of BIRTH  Arts Of BIRTH  9/AGE (In years   IF UND    Months  Arts Of BIRTH	ER 1 YEAR IF UNDER 24 HRS Days Hours Min
		O USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTR during most of working life, even if retired)	1) 8 RTHELACT (State or foreign country) 12 (	TI. S. A.
		Welling Samon	14. MOTHER'S MAIDEN NAME	
,		(a) NO OF UNITOWN   IT YES GIVE WOT OF GOTTON OF SETTING   THE STATE OF THE STATE O	Helen Woods 3120 Le Ya	mfdt. Bull ry
		PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a).	seula accident	INTERVAL BETWEEN ONSET AND DEATH
		Conditions, if any, which	10 40	
		gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO  (c)  Liberaine  (c)	thewselverin	20420
1	CATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN P	ART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO. R
	RTIE	190- ACCIDENT MAR INDEPENDING ET 1905 DESCRIPT MONTHURY OCCUPAND	Enter nature of injury in Part 1 or Part II of item 18 )	
	MEDICAL	20c TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Hour a. m. While Not while factor at work at work at work	OF INJURY (Home, farm, 20f. (City or tawn) y, street, affice bldg , etc.)	(County) (State)
		21. I certify that I attended the deceased fram UNI.		I last saw the deceased
		alive an 19 and that death o	ccurred at 2 2 M, fram the causes and on ADDRESS (Street, city or town, state)	the date stated above.  DATE SIGNED
1		ACTUAL SIGNATURE	SILESULLE , 1	1 Del/27/59
1		PHYSICIAN'S 19. V. HOUCK		
		PO BURIAL CREMATION, 226. DATE THEREOF 22c NAME OF CEMETERY OR GENEVAL SPORTS	22d LOCATION (Gity town, or county	(State)
	23	FINERAL SPRICTOR'S SIGNATURE ADDRESS ADDRESS SIGNATURE ADDRESS SIG	DATE PER A DO REGISTRAR 246 REGISTRAR'S	SIGNATURE & Krassa



.... La Principal Land 

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY o. STATE. filed B. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If aptside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION 20 4. DATE OF DEATH 3. NAME OF Middle Lost Month DECEASED ZEPP ELSIE IRENE (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE [In years lost birthdoy) WIDOWED D DIVORCED | USUAL OCCUPATION (Give kind of work done 106. KIND OF BUSINESS OR INDOSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if reliped) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicic remove c WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 3 18. CAUSE OF DEATH [Enter only one couse per line for (q), (b), and (c).] ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate **DUE TO** cosse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Act II of item 18.) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) Day, Year factory, street, office bldg., etc.) Hour o. m. Not while of work of work

and that death accurred of

240 REC'D BY REGISTRAR

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

21. I certify that I attended the deceased from

226. DATE THEREOF

alive on\_

ACTUAL SIGNATURE

NAME (Type)

BURIAL, CREMATION,

23. FUNERAL DIRECTOR'S SIGNATURE

REMOVAL (Specify)

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DIE P

Page 3 sh

VS A15 (4) 1SM 9/SS

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Reg. Dist. No e. IS RESIDENCE ON A FARM? YES NO PA Day Year 190 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? INTERVAL BETWEEN PERFORMED? YES NO (County) (Stote) 125 2, that I last sow the deceased M, from the causes and on the date stated above. ADDRESS (Street, city or town, stotel DATE SIGNED 22d. LOCATION (City, town, or county) (State) 24b. REGISTRAR'S SIGNATURE

